Public Laws: 102nd Congress 1st & 2nd Congress
/ Senate Reports / 1991 and 1992

Calendar No. 669

102D CONGRESS *2d Session*	SENATE	REPORT 102-401

VETERANS HEALTH PROGRAMS IMPROVEMENT ACT OF 1992

REPORT

OF THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

TO ACCOMPANY

S. 2575

SEPTEMBER 15 (legislative day, SEPTEMBER 8), 1992.—Ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE
58-915 WASHINGTON : 1992

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CONTENTS

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VETERANS HEALTH PROGRAMS IMRPOVEMENT ACT OF 1992

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Mr. CRANSTON, from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany S. 2575]

The Committee on Veterans' Affairs, to which was referred the bill (S. 2575) to amend chapter 74 of title 38, United States Code, to revise certain pay authorities that apply to nurses and other health care professionals, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a committee substitute and an amendment to the title, and recommends that the bill, as amended, do pass.

COMMITTEE AMENDMENTS

The amendments are as follows:

Strike out all after the enacting clause as follows:

[SECTION 1. SHORT TITLE; REFERENCE TO TITLE 38.

[(a) SHORT TITLE.—This Act may be cited as the "Department of Veterans Affairs Nurse Pay Amendments of 1992".

[(b) REFERENCES TO TITLE 38.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

[SEC. 2. REVISION TO NURSE PAY GRADE SCHEDULE.

[(a) REVISION.—Section 7404(b)(1) is amended in the matter relating to "NURSE SCHEDULE" by striking out "Director grade." and all that follows through "Entry grade." and inserting in lieu thereof the following:

["Nurse V.
["Nurse IV.
["Nurse III.
["Nurse II.
["Nurse I.".

[(b) CONFORMING AMENDMENT.—Section 7451(b) of such title is amended by striking out "four" and inserting in lieu thereof "five".

[SEC. 3. PERMANENT AUTHORITY TO WAIVE CERTAIN LIMITATIONS APPLICABLE TO RECEIPT OF RETIREMENT PAY BY NURSES.

[Section 7426(c) is amended by striking out the second sentence.

[SEC. 4. AUTHORITY TO ESTABLISH SPECIAL RATES OF PAY FOR EMPLOYEES OF FACILITIES LOCATED OUTSIDE THE CONTIGUOUS UNITED STATES, ALASKA, AND HAWAII.

[Section 7451(a)(3) is amended—

[(1) by striking out "(3) The rates" and inserting in lieu thereof "(3)(A) Except as provided in subparagraph (B), the rates"; and

[(2) by adding at the end the following new subparagraph:

["(B) Under such regulations as the Secretary shall prescribe, the Secretary shall establish and adjust the rates of basic pay for covered positions at the following health-care facilities in order to provide rates that enable the Secretary to recruit and retain sufficient numbers of health-care personnel in such positions at such facilities:

["(i) The Veterans Memorial Medical Center in the Republic of the Philippines.

["(ii) Department of Veterans Affairs health-care facilities located outside the contiguous States, Alaska, and Hawaii.".

[SEC. 5. AUTHORITY TO CARRY OUT CERTAIN SURVEYS OF LABOR MARKETS IN DETERMINING RATES OF COMPENSATION OF HEALTH CARE PROFESSIONALS.

[Section 7451(d)(3) is amended—

[(1) by redesignating subparagraph (C) and (D) as subparagraphs (E) and (F), respectively; and

[(2) by inserting after subparagraph (B) the following new subparagraphs (C) and (D):

["(C) In the event that the director of a Department health-care facility who conducts a survey of beginning rates of compensation for corresponding health-care professionals in the labor-market area of the facility under subparagraph (B) determines (under regulations prescribed by the Secretary) that the size or composition of the labor-market area provides information that is not sufficient to permit the adjustments referred to in that subparagraph for the applicable covered positions, the director may conduct a survey of such rates of compensation in other comparable labor-market areas (as so determined). Any survey under this subparagraph shall be conducted in accordance with the provisions of subparagraph (B).

["(D) In the event that the director of a Department health-care facility who conducts a survey of beginning rates of compensation for certified registered nurse anesthetists in the labor-market area of the facility under subparagraph (B), and, if appropriate, a survey of such rates of compensation for such nurse anesthetists in comparable labor-market areas under subparagraph (C), determines (under regulations prescribed by the Secretary) that neither of the survey methods described in such subparagraphs is sufficient to permit the adjustments referred to in subparagraph (B) for such nurse anesthetists employed by the facility, the director may use data on the compensation paid to such nurse anesthetists under contracts with entities that provide anesthesia services through such nurse anesthetists in the labor-market area.".

[SEC. 6. REVISION OF BASIS FOR CALCULATION OF COMPENSATION OF CORRESPONDING HEALTH CARE POSITIONS.

[Section 7451(d)(6)(A)(i) is amended by striking out "established" and inserting in lieu thereof "paid".

[SEC. 7. ADJUSTMENT IN GRADE OR STEP OF CERTAIN HEALTH-CARE PROFESSIONALS WHO TRANSFER TO OTHER DEPARTMENT OF VETERANS AFFAIRS FACILITIES.

[(a) AUTHORITY TO ADJUST.—Subsection (e) of section 7452 is amended—

[(1) by striking out "(e) An employee" and inserting in lieu thereof "(e)(1) Except as provided in paragraph (2), an employee"; and

[(2) by adding at the end the following new paragraph (2):

["(2) The Secretary may establish for an employee referred to in paragraph (1) who transfers (upon the request of the Secretary) to that facility a rate of basic pay that is higher than the rate of basic pay otherwise paid by that facility to an employee of that grade and step if the Secretary determines that such rate of pay is necessary to recruit the employee for employment in that facility. Whenever the Secretary exercises the authority under the preceding sentence relating to the rate of basic pay of a transferred employee, the Secretary shall, in the next annual report required under section 7451(g) of this title, provide justification for doing so.".

[(b) CONFORMING AMENDMENT.—Section 7451(g) is amended by adding at the end the following new paragraph:

["(9) The justification required by section 7452(e)(2) of this title.".

[SEC. 8. PERMANENT AUTHORITY TO FURNISH RESPITE CARE.

[Section 1720B is amended by striking out subsection (c).

[SEC. 9. EXTENSION OF AUTHORITY TO ENTER INTO CONTRACTS WITH RESPECT TO THE VETERANS MEMORIAL MEDICAL CENTER IN THE PHILIPPINES.

[Section 1732(a) is amended in the matter above paragraph (1) by striking out "September 30, 1992," and inserting in lieu thereof "December 31, 1996,".

[SEC. 10. PERMANENT AUTHORITY TO CARRY OUT HEALTH PROFESSIONAL SCHOLARSHIP PROGRAM.

[(a) PERMANENT AUTHORITY.—Subchapter II of chapter 76 is amended by striking out section 7618.

[(b) TECHNICAL AMENDMENT.—The table of sections at the beginning of such chapter 76 is amended by striking out the item relating to section 7618.

[SEC. 11. PERMANENT AUTHORITY TO MAKE GRANTS TO STATES RELATING TO STATE HOMES.

[Section 8133(a) is amended in the first sentence by striking out "through September 30, 1992." and inserting in lieu thereof a period.]

and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; REFERENCE TO TITLE 38.

(a) SHORT TITLE.—This Act may be cited as the "Veterans Health Programs Improvement Act of 1992".

(b) REFERENCES TO TITLE 38.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—NURSE PAY

SEC. 101. REVISION TO NURSE PAY GRADE SCHEDULE.

(a) REVISION.—Section 7404(b)(1) is amended in the matter relating to "NURSE SCHEDULE" by striking out "Director grade." and all that follows through "Entry grade." and inserting in lieu thereof the following:

"Nurse V.
"Nurse IV.
"Nurse III.
"Nurse II.
"Nurse I.".

(b) CONFORMING AMENDMENT.—Section 7451(b) of such title is amended by striking out "four" and inserting in lieu thereof "five".

SEC. 102. AUTHORITY TO ESTABLISH SPECIAL RATES OF PAY FOR EMPLOYEES OF FACILITIES LOCATED OUTSIDE THE CONTIGUOUS UNITED STATES, ALASKA, AND HAWAII.

Section 7451(a)(3) is amended—

(1) by striking out "(3) The rates" and inserting in lieu thereof "(3)(A) Except as provided in subparagraph (B), the rates"; and

(2) by adding at the end the following new subparagraph:

"(B) Under such regulations as the Secretary shall prescribe, the Secretary shall establish and adjust the rates of basic pay for covered positions at the following health-care facilities in order to provide rates that enable the Secretary to recruit and retain sufficient numbers of health-care personnel in such positions at such facilities:

"(i) The Veterans Memorial Medical Center in the Republic of the Philippines.

"(ii) Department of Veterans Affairs health-care facilities located outside the contiguous States, Alaska, and Hawaii.".

SEC. 103. AUTHORITY TO CARRY OUT CERTAIN SURVEYS OF LABOR MARKETS IN DETERMINING RATES OF COMPENSATION OF HEALTH CARE PROFESSIONALS.

Section 7451(d)(3) is amended—

(1) by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively; and

(2) by inserting after subparagraph (B) the following new subparagraphs (C) and (D):

"(C) In the event that the director of a Department health-care facility who conducts a survey of beginning rates of compensation for corresponding health-care professionals in the labor-market area of the facility under subparagraph (B) determines (under regulations prescribed by the Secretary) that the size or composition of the labor-market area provides information that is not sufficient to permit the adjustments referred to in that subparagraph for the applicable covered positions, the director may conduct a survey of such rates of compensation in other comparable labor-market areas (as so determined). Any survey under this subparagraph shall be conducted in accordance with the provisions of subparagraph (B).

"(D) In the event that the director of a Department health-care facility who conducts a survey of beginning rates of compensation for certified registered nurse anesthetists in the labor-market area of the facility under subparagraph (B), and, if appropriate, a survey of such rates of compensation for such nurse anesthetists in comparable labor-market areas under subparagraph (C), determines (under regulations prescribed by the Secretary) that neither of the survey methods described in such subparagraphs is sufficient to permit the adjustments referred to in subparagraph (B) for such nurse anesthetists employed by the facility, the director may use data on the beginning rates of compensation paid to certified registered nurse anesthetists who are employed on a salary basis by entities that provide anesthesia services through certified registered nurse anesthetists in the labor-market area. For the purposes of this subparagraph, certified registered nurse anesthetists who are so employed by such entities shall be deemed to be corresponding health-care professionals to the certified registered nurse anesthetists employed by the facility. ".

SEC. 104. REVISION OF BASIS FOR CALCULATION OF COMPENSATION OF CORRESPONDING HEALTH CARE POSITIONS.

Section 7451(d)(6)(A)(i) is amended by striking out "established" and inserting in lieu thereof "paid".

SEC. 105. ADJUSTMENT IN GRADE OR STEP OF CERTAIN HEALTH-CARE PROFESSIONALS WHO TRANSFER TO OTHER DEPARTMENT OF VETERANS AFFAIRS FACILITIES.

(a) AUTHORITY TO ADJUST.—Subsection (e) of section 7452 is amended—

(1) by inserting "(1)" after "(e)"; and

(2) by adding at the end the following new paragraph (2):

"(2) The Secretary may establish for an employee referred to in paragraph (1) who transfers upon the request of the Secretary (but not pursuant to a disciplinary action otherwise authorized by law) to a new facility a rate of basic pay that is higher than the rate of basic pay otherwise paid by the new facility to an employee of that grade and step if the Secretary determines that such rate of pay is necessary to recruit the employee for employment in the new facility. Whenever the Secretary exercises the authority under the preceding sentence relating to the rate of basic pay of a transferred employee, the Secretary shall, in the next annual report required under section 7451(g) of this title, provide justification for doing so.".

(b) CONFORMING AMENDMENT.—Section 7451(g) is amended by adding at the end the following new paragraph:

"(9) The justification required by section 7452(e)(2) of this title.".

TITLE II—PREVENTIVE HEALTH CARE

SEC. 201. IMPROVEMENT OF PREVENTIVE HEALTH SERVICES.

(a) IN GENERAL.—The text of section 1762 is—

(1) transferred to section 1701; and

(2) redesignated as paragraph (9) of such section 1701.

(b) IMPROVEMENT.—Such paragraph (9) is amended—

(1) by striking out "For the purposes of this subchapter, the term 'preventive health-care services' means" and inserting in lieu thereof "The term 'preventive health services' means";

(2) by redesignating paragraphs (1), (2), (3), (4), (5), (6), (7), (8), (9), (10), and (11) as subparagraphs (A), (B), (C), (D), (E), (F), (G), (H), (I), (J), and (K), respectively; and

(3) by striking out subparagraphs (A) and (B) (as so redesignated) and inserting in lieu thereof the following:

"(A) periodic medical and dental examinations (including screening for high blood pressure, glaucoma, high cholesterol, and colorectal and gender-specific cancers);

"(B) patient health education (including education relating to nutrition, stress management, physical fitness, and stopping smoking);".

(c) CONFORMING AMENDMENT.—Section 1701(6)(A)(i) is amended by striking out "preventive health-care services as defined in section 1762 of this title," and inserting in lieu thereof "preventive health services,".

(d) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall take effect on the date of the enactment of this Act.

SEC. 202. REPEAL OF PILOT PROGRAM.

(a) REPEAL.—Subchapter VII of chapter 17 is repealed.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by striking out the matter relating to subchapter VII.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act.

SEC. 203. NATIONAL CENTER FOR PREVENTIVE HEALTH.

(a) ESTABLISHMENT.—(1) Subchapter II of chapter 73 is amended by adding at the end the following new section:

"§ 7318. National Center for Preventive Health

"(a)(1) The Chief Medical Director shall establish and operate in the Veterans Health Administration a National Center for Preventive Health (hereafter in this section referred to as the 'Center').

"(2) The head of the Center is the Director of Preventive Health (hereafter in this section referred to as the 'Director').

"(3) The Chief Medical Director shall provide the Center with such staff and other support as may be necessary for the Center to carry out effectively its functions under this section.

"(b) The purposes of the Center are as follows:

"(1) To provide a central office for monitoring and encouraging the activities of the Veterans Health Administration with respect to the provision, evaluation, and improvement of preventive health services.

"(2) To promote the expansion and improvement of clinical, research, and educational activities of the Veterans Health Administration with respect to such services.

"(c) In carrying out the purposes of the Center under this section, the Director shall—

"(1) develop and maintain current information on clinical activities of the Veterans Health Administration relating to preventive health services, including activities relating to—

"(A) the on-going provision of regularly-furnished services; and

"(B) patient education and screening programs carried out throughout the Administration;

"(2) develop and maintain detailed current information on research activities of the Veterans Health Administration relating to preventive health services;

"(3) in order to encourage the effective provision of preventive health services by Veterans Health Administration personnel—

"(A) ensure the dissemination to such personnel of any appropriate information on such services that is derived from research carried out by the Administration; and

"(B) acquire and ensure the dissemination to such personnel of any appropriate information on research and clinical practices relating to such services that are carried out by researchers, clinicians, and educators who are not affiliated with the Administration;

"(4) encourage and monitor the implementation within the Veterans Health Administration of the recommendations on preventive health services of the Advisory Committee on Preventative Health Services established under section 7319 of this title;

"(5) ensure transmission to the Advisory Committee of inquiries of the Secretary or the Chief Medical Director, and the responses of the Advisory Committee to such inquiries;

"(6) facilitate the optimal use of the unique resources of the Department for cooperative research into health outcomes by initiating recommendations, and responding to requests of the Chief Medical Director and the Director of the Medical and Prosthetic Research Service, for such research into preventive health services; and

"(7) provide advisory services to personnel of Department health-care facilities with respect to the planning or furnishing of preventive health services by such personnel.

"(d) In this section, the term 'preventive health services' has the meaning given such term in section 1701(9) of this title.".

(2) The table of sections at the beginning of chapter 73 is amended by adding after the item relating section 7317 the following:

"7318. National Center for Preventive Health.".

(b) POSITION OF DIRECTOR OF CENTER.—

(1) POSITION.—Subsection (a) of section 7306 is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6) the following new paragraph (7):

"(7) The Director of the National Center for Preventive Health, who shall be responsible to the Chief Medical Director for the operation of the Center.".

(2) CONFORMING AMENDMENT.—Subsection (c) of such section is amended in the second sentence by striking out "and (4)" and inserting in lieu thereof "(4), and (7)".

(c) ANNUAL REPORT.—(1) Not later than August 31, 1993, and on an annual basis thereafter, the National Center for Preventive Health established under section 7318 of title 38, United States Code (as added by subsection (a)), shall issue a report on the programs, activities, and findings of the Department of Veterans Affairs on preventive health services during the 12-month period preceding the date of the report to health-care professionals and organizations that have an interest in the provision of such services.

(2) In this subsection, the term 'preventive health services' has the meaning given such term in section 1701(9) of title 38, United States Code (as added by section 201 of this Act).

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $2,500,000 to the Medical Care General and Special Fund of the Department of Veterans Affairs for each fiscal year after fiscal year 1992 for the purpose of permitting the National Center for Preventive Health established under section 7318 of title 38, United States Code (as added by subsection (a)), to carry out research, clinical, educational, and administrative activities under such section 7318. Such activities shall be deemed to be part of the operation of health-care facilities of the Department without regard to the location at which such activities are carried out.

SEC. 204. ADVISORY COMMITTEE ON PREVENTIVE HEALTH SERVICES.

(a) ESTABLISHMENT.—Subchapter II of chapter 73, as amended by section 203 of this Act, is further amended by inserting after section 7318 the following new section:

"§ 7319. Preventive Health Services Advisory Committee

"(a) The Secretary shall establish a Preventive Health Services Advisory Committee (hereafter in this section referred to as the 'Committee').

"(b)(1) The membership of the Committee shall be appointed by the Secretary, upon the recommendation of the Chief Medical Director, from individuals who are not employees of the Department, and shall include individuals who are not employees of the Federal Government and who have demonstrated interest and expertise in research, education, and clinical activities related to the provision of preventive health services, and at least one representative of veterans who receive health-care services from the Veterans Health Administration.

"(2) The Secretary, upon the recommendation of the Chief Medical Director, shall invite appropriate representatives of other departments and agencies of the Federal Government to participate in the activities of the Committee.

"(3) The Secretary shall provide the Committee with such staff and other support as may be necessary for the Committee to carry out effectively its functions under this section.

"(c)(1) The Committee shall—

"(A) identify for the Secretary—

"(i) the types of preventive health services that are appropriate for particular groups of veterans; and

"(ii) the areas of inquiry within the field of such services that the Committee determines to be suitable for the pursuit of new or additional clinical research by the Department;

"(B) make recommendations to the Secretary on—

"(i) various means of initiating, enhancing, modifying, or discontinuing the provision of preventive health services by the Department in order to

ensure that such groups of veterans are provided with appropriate preventive health services; and

"(ii) various means of ensuring the continued provision of preventive health services by the Department;

"(C) advise the Secretary on general developments in the fields of research and clinical activities related to preventive health services; and

"(D) respond to requests of the Secretary or the Chief Medical Director for information on specific research and clinical activities and ethical matters related to such activities.

"(2) The Committee shall transmit any identifications, recommendations, and advice to the Secretary under subparagraphs (A), (B), and (C) of paragraph (1) through the Chief Medical Director.

"(d)(1) Not later than August 1, 1993, and on an annual basis thereafter, the Committee shall submit to the Secretary a report on the activities of the Committee with respect to the matters referred to in subsection (c)(1) during the 12-month period preceding the date of the report.

"(2) The Committee shall submit to the Secretary, through the Chief Medical Director, such reports in addition to the reports referred to in paragraph (1) as the Committee considers appropriate with respect to the matters referred to in subsection (c)(1). Not later than 90 days after receipt of a report under this paragraph, the Secretary shall transmit the report, together with the Secretary's comments and recommendations thereon, to the appropriate committees of the Congress.

"(e) In this section, the term 'preventive health services' has the meaning given such term in section 1701(9) of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by inserting after the item relating to section 7318, as added by section 203 of this Act, the following:

"7319. Preventive Health Services Advisory Committee.".

SEC. 205. REPORTS.

(a) REPORTS.—Not later than October 31, 1993, and on an annual basis thereafter, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report including the following:

(1) A description of the programs and activities of the Department of Veterans Affairs with respect to preventive health services during the 12-month period preceding the date of the report, including—

(A) the programs conducted by the Department—

(i) to educate veterans with respect to health promotion and disease prevention; and

(ii) to provide veterans with preventive health screenings and other clinical services, with such description setting forth the types of resources used by the Department to conduct such screenings and services and the number of veterans reached by such screenings and services;

(B) the means by which the Secretary addressed the specific preventive health services needs of particular groups of veterans (including veterans with service-connected disabilities, elderly veterans, low-income veterans, women veterans, institutionalized veterans, and veterans who are at risk for mental illness);

(C) the manner in which the provision of such services was coordinated with the activities of the Medical and Prosthetic Research Service of the Department and the National Center for Preventive Health;

(D) the manner in which the provision of such services was integrated into training programs of the Department, including initial and continuing medical training of medical students, residents, and Department staff;

(E) the manner in which the Department participated in cooperative preventive health efforts with other governmental and private entities (including State and local health promotion offices and not-for-profit organizations);

(F) the specific research carried out by the Department with respect to the long-term relationships among screening activities, treatment, and morbidity and mortality outcomes; and

(G) the cost effectiveness of such programs and activities, including an explanation of the means by which the costs and benefits (including the quality of life of veterans who participate in such programs and activities) of such programs and activities are measured.

(2) A specific description of research activities on preventive health services carried out during that period using employees, funds, equipment, office space, or other support services of the Department, with such description setting forth—

(A) the source of funds for such activities;

(B) the articles or publications (including the authors of such articles and publications) in which such activities are described;

(C) the Federal, State, or local governmental entity or private entity, if any, with which such activities were carried out; and

(D) the clinical, research, or staff education projects for which funding applications were submitted (including the source of the funds applied for) and upon which a decision is pending or was denied.

(3) With respect to the Preventive Health Services Advisory Committee established under section 7319 of title 38, United States Code (as added by section 204 of this Act)—

(A) the membership list of the Advisory Committee during the 12-month period preceding the date of the report;

(B) a description of matters referred by the Secretary or the Chief Medical Director of the Department to the Advisory Committee during that period;

(C) the most recent annual report submitted to the Secretary by the head of the Advisory Committee;

(D) the comments and recommendations of the Secretary, after consultation with the Chief Medical Director, with respect to that annual report; and

(E) a description of any activities of the Department to carry out any proposals or recommendations contained in that annual report.

(4) An accounting of the expenditure of funds during that period by the National Center for Preventive Health established under section 7318 of title 38, United States Code (as added by section 204 of this Act).

(b) DEFINITION.—In this section, the term "preventive health services" has the meaning given such term in section 1701(9) of title 38, United States Code (as added by section 201 of this Act).

TITLE III—STATE HOME FACILITIES

SEC. 301. TREATMENT OF COMPENSATION OF VETERANS UNDER CERTAIN REHABILITATIVE SERVICES PROGRAMS.

Section 1718 is amended by adding at the end the following new subsection:

"(g)(1) Neither a veteran's participation in a program of rehabilitative services that is provided as part of the veteran's care furnished by a State home and is approved by the Secretary as conforming appropriately to standards for activities carried out under this section nor a veteran's receipt of payment as a result of such participation may be considered as a basis for the denial or discontinuance of a rating of total disability for purposes of compensation or pension based on the veteran's inability to secure or follow a substantially gainful occupation as a result of disability.

"(2) A payment made to a veteran under a program of rehabilitative services described in paragraph (1) shall be considered for the purposes of chapter 15 of this title to be a donation from a public or private relief or welfare organization.".

SEC. 302. EXTENSION OF PERIOD FOR COMPLETION OF CONDITIONALLY APPROVED APPLICATIONS FOR CONSTRUCTION.

(a) EXTENSION OF PERIOD.—Section 8135(b)(6)(A) is amended by striking out "90 days" and inserting in lieu thereof "180 days".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on October 1, 1992, and shall apply to projects conditionally approved on or after that date.

SEC. 303. LIMITED PROHIBITION ON OBLIGATION OF FUNDS FOR RESCINDED PROJECTS.

(a) PROHIBITION.—Section 8135(b)(6)(B) is amended by adding at the end the following: "In the event the Secretary rescinds conditional approval of a project under this subparagraph, the Secretary may not further obligate funds for the project during the fiscal year in which the Secretary rescinds such approval.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on October 1, 1992, and shall apply to rescissions made on or after that date.

SEC. 304. COMMENCEMENT DATE FOR RECAPTURE PERIOD.

(a) COMMENCEMENT DATE.—Section 8136 is amended by striking out "within 20 years after completion of any project" and inserting in lieu thereof "within the 20-year period beginning on the date of the approval by the Secretary of the final architectural and engineering inspection of any project".

(b) TECHNICAL AMENDMENT.—Such section is further amended by striking out "such facilities cease" and inserting in lieu thereof "the facilities covered by the project cease".

SEC. 305. COMMENCEMENT DATE FOR PAYMENT OF PER DIEM.

Section 1741 is amended by adding at the end the following:

"(e) Subject to section 1743, the payment of per diem for care furnished in a State home facility shall commence on the date of the completion of the inspection for recognition of the facility under section 1742(a) of this title if the Secretary determines, as a result of that inspection, that the State home meets the standards described in such section 1742(a).".

TITLE IV—RURAL HEALTH-CARE CLINICS

SEC. 401. RURAL HEALTH-CARE CLINIC PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Chapter 17 is amended by adding at the end of subchapter II the following new section:

"§ 1720D. Health care through rural clinics

"(a) During the three-year period beginning on October 1, 1992, the Secretary shall conduct a rural health-care clinic program in States where significant numbers of veterans reside in areas geographically remote from existing health-care facilities (as determined by the Secretary). The Secretary shall conduct the program in accordance with this section.

"(b)(1) In carrying out the rural health-care clinic program, the Secretary shall furnish medical services to the veterans described in subsection (c) through use of—

"(A) mobile health-care clinics equipped, operated, and maintained by personnel of the Department; and

"(B) other types of rural clinics, including part-time stationary clinics for which the Secretary contracts and part-time stationary clinics operated by personnel of the Department.

"(2) The Secretary shall furnish services under the rural health-care clinic program in areas—

"(A) that are more than 100 miles from a Department general health-care facility; and

"(B) that are less than 100 miles from such a facility, if the Secretary determines that the furnishing of such services in such areas is appropriate.

"(c) A veteran eligible to receive medical services through rural health-care clinics under the program is any veteran eligible for medical services under section 1712 of this title.

"(d) The Secretary shall commence operation of at least three rural health-care clinics (at least one of which shall be a mobile health-care clinic) in each fiscal year of the program. The Secretary may not operate more than one mobile health-care clinic under the authority of this section in any State in any such fiscal year.

"(e) Not later than December 31, 1996, the Secretary shall submit to Congress a report containing an evaluation of the program. The report shall include the following:

"(1) A description of the program, including information with respect to—

"(A) the number and type of rural health-care clinics operated under the program;

"(B) the States in which such clinics were operated;

"(C) the medical services furnished under the program, including a detailed specification of the cost of such services;

"(D) the veterans who were furnished services under the program, setting forth (i) the numbers and percentages of the veterans who had service-connected disabilities, (ii) of the veterans having such disabilities, the numbers and percentages who were furnished care for such disabilities, (iii) the ages of the veterans, (iv) taking into account the veterans' past use of Department health-care facilities, an analysis of the extent to which the veterans would have received medical services from the Department outside the pro-

gram and the types of services they would have received, and (v) the financial circumstances of the veterans; and

"(E) the types of personnel who furnished services to veterans under the program, including any difficulties in the recruitment or retention of such personnel.

"(2) An assessment by the Secretary of the cost-effectiveness and efficiency of furnishing medical services to veterans through various types of rural clinics (including mobile health-care clinics operated under the pilot program conducted pursuant to section 113 of the Veterans' Benefits and Services Act of 1988 (Public Law 100–322; 38 U.S.C. 1712 note)).

"(3) Any plans for administrative action, and any recommendations for legislation, that the Secretary considers appropriate.

"(f) For the purposes of this section, the term 'Department general health-care facility' has the meaning given such term in section 1712A(i)(2) of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1720C the following new item:

"1720D. Health care through rural clinics.".

(c) AUTHORIZATION OF APPROPRIATIONS.—(1) There is authorized to be appropriated to the Department of Veterans Affairs to carry out the rural health-care clinics program provided for in section 1720D of title 38, United States Code (as added by subsection (a)), the following:

(A) For fiscal year 1993, $3,000,000.

(B) For fiscal year 1994, $6,000,000.

(C) For fiscal year 1995, $9,000,000.

(2) Amounts appropriated pursuant to such authorization may not be used for any other purpose.

(3) No funds may be expended to carry out the rural health-care clinics program provided for in such section 1720D (as so added) unless expressly provided for in an appropriations Act.

TITLE V—TELEPHONE USE DEMONSTRATION PROJECT

SEC. 501. DEMONSTRATION PROJECTS TO EVALUATE TELEPHONES FOR PATIENT USE AT DEPARTMENT HEALTH-CARE FACILITIES.

(a) DEMONSTRATION PROJECTS.—In accordance with this section, the Secretary of Veterans Affairs shall carry out demonstration projects to evaluate the feasibility and desirability of—

(1) the installation of telephones in Department of Veterans Affairs health-care facilities; and

(2) the use of such telephones by the patients of such health-care facilities.

(b) DEMONSTRATION FACILITIES.—The Secretary shall carry out a demonstration project under this section at the following Department health-care facilities:

(1) Philadelphia Department of Veterans Affairs Medical Center, Philadelphia, Pennsylvania.

(2) Tucson Department of Veterans Affairs Medical Center, Tucson, Arizona.

(c) PROJECT ACTIVITIES.—(1) In carrying out a demonstration project under this section at a facility referred to in subsection (b), the Secretary shall—

(A) install and maintain telephones of an appropriate number and type (as determined by the Secretary) in patient rooms of the facility; and

(B) subject to paragraph (2), provide for the use of such telephones by patients who are assigned to such rooms while receiving care at the facility.

(2) The Secretary shall ensure that patients who use telephones pursuant to paragraph (1)(B) shall bear financial responsibility for the cost of any long-distance telephone calls made during such use.

(d) PROJECT EVALUATION.—In evaluating the feasibility and desirability of the installation and use of the telephones referred to in subsection (c), the Secretary shall determine—

(1) the cost to each health-care facility referred to in subsection (b) of the installation, use, and maintenance of such telephones, including—

(A) the cost to the facility of such installation, use, and maintenance;

(B) the amount of any savings which accrue to the facility by reason of such installation and use (including the amount of any savings that result

from a decrease in the amount of assistance in using telephones that the staff of the facility would otherwise provide to patients); and

(C) any costs that result from the necessity of providing special telephones or other special equipment to facilitate the use of telephones by disabled veterans (including veterans who are receiving long term psychiatric care or nursing care or who are blind or hearing impaired); and

(2) the impact of the use of such telephones on the therapeutic course of veterans who receive care at the facility, including the veterans referred to in paragraph (1)(C).

(e) REPORT.—Not later than September 30, 1994, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report containing—

(1) the determinations of the Secretary under subsection (d);

(2) an assessment by the Secretary of the feasibility and desirability of providing telephones for patients in other health-care facilities of the Department; and

(3) any additional information and recommendations with respect to the provision and use of patient telephones at Department health-care facilities as the Secretary considers appropriate.

TITLE VI—PROCUREMENT OF PHARMACEUTICALS

SEC. 601. SHORT TITLE.

This title may be cited as the "Federal Health Programs Pharmaceutical Pricing Act of 1992".

SEC. 602. MASTER AGREEMENTS WITH GENERAL SERVICES ADMINISTRATION.

(a) IN GENERAL.—The Federal Property and Administrative Services Act of 1949 (40 U.S.C. 471 et seq.) is amended by adding at the end thereof the following new title:

"TITLE X—PHARMACEUTICAL PRICING AGREEMENTS

"SEC. 1001. MASTER AGREEMENTS.

"(a) IN GENERAL.—(1)(A) A manufacturer of a drug or biological may not—

"(i) sell drugs or biologicals to any Federal agency described under subsection (b),

"(ii) be deemed to have an agreement under section 1927 of the Social Security Act (42 U.S.C. 1396r-8), or

"(iii) receive payment for the purchase of a drug or biological directly or indirectly from any entity that receives funds under the Public Health Service Act (42 U.S.C. 201 et seq.),

unless such manufacturer enters into an agreement with the Administrator as described in subparagraph (B)(i) within 5 months of the date of the enactment of this title or, in the case of a drug or biological first marketed by such manufacturer after such date, such manufacturer complies with the requirements of paragraph (2).

"(B)(i) An agreement is described in this subparagraph if such agreement requires a manufacturer referred to in subparagraph (A) to enter into one or more pharmaceutical pricing agreements with Federal agencies desiring such agreements with respect to any drug or biological marketed by such manufacturer within 6 months of the date of the enactment of this title, or, if such a pricing agreement is not desired by a Federal agency within such period, within 30 days after such Federal agency requests such a pricing agreement.

"(ii) The Administrator shall prescribe procedures under which a Federal agency shall notify a drug or biological manufacturer that the Federal agency desires to enter into a pharmaceutical pricing agreement under clause (i).

"(2) Any manufacturer of a drug or biological first marketed after the date of the enactment of this title shall—

"(A) within 2 months after the date such marketing begins—

"(i) if the manufacturer has an agreement with the Administrator under paragraph (1)(A), enter into an amendment of such agreement with respect to such drug or biological, or

"(ii) if the manufacturer does not have an agreement with the Administrator under paragraph (1)(A), enter into such an agreement with respect to such drug or biological; and

"(B) enter into pharmaceutical pricing agreements with respect to such drug or biological—

"(i) within 3 months after the date such marketing begins; or

"(ii) if such a pricing agreement is not desired by a Federal agency within such 3-month period, within 30 days after such Federal agency requests such a pricing agreement.

"(b) FEDERAL AGENCIES.—Federal agencies described in this subsection are as follows:

"(1) The Department of Veterans Affairs with respect to sales to the Department of Veterans Affairs and State homes receiving funds under section 1741 of title 38, United States Code.

"(2) The Department of Defense.

"(3) The Department of Health and Human Services with respect to sales to the Public Health Service and certain clinics described in section 2145(a) of the Public Health Service Act.

"(c) PHARMACEUTICAL PRICING AGREEMENTS.—For purposes of subsection (a), the term 'pharmaceutical pricing agreement' means an agreement or amendments to an agreement in force on the date of the enactment of this title with any Federal agency described in subsection (b) or with the Department of Health and Human Services under title XIX of the Social Security Act regarding pharmaceutical pricing and subject to the following relevant provisions:

"(1) Subchapter VI of chapter 81 of title 38, United States Code.

"(2) Section 1107 of title 10, United States Code.

"(3) Section 1927 of the Social Security Act (42 U.S.C. 1396r-8).".

SEC. 603. PRICES OF DRUGS AND BIOLOGICALS UNDER THE FEDERAL SUPPLY SCHEDULE.

(a) IN GENERAL.—Chapter 81 is amended by adding at the end the following new subchapter:

"SUBCHAPTER VI—PROCUREMENT OF DRUGS AND BIOLOGICALS

"§ 8171. Definitions

"For the purposes of this subchapter—

"(1) The term 'additional price discount amount', in the case of the price of a drug or biological whose price is established under an agreement under this subchapter, means—

"(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months, the amount of the difference, if any, between—

"(i) the Federal average price differential (as determined under paragraph (6)(A)); and

"(ii) the amount equal to—

"(I) the Federal average manufacturer price of the drug or biological for the 3-month period ending on the date that is 12 months before the last day of the last month before the effective date of the agreement for which price index data and price data for the drug or biological are available, multiplied by

"(II) the percentage increase in the price index during that 12-month period; or

"(B) in the case of a drug or biological for which such data does not permit the calculation of that price for as many months, the amount of the difference, if any, between—

"(i) the Federal average price differential (as determined under paragraph (6)(B)); and

"(ii) an amount equal to—

"(I) the Federal average manufacturer price of the drug or biological for the 3-month period beginning on the first day of the month next following the month in which marketing of the drug or biological begins, multiplied by

"(II) the percentage increase in the price index during the period beginning on such day and ending on the last day of the last

month before the effective date of the agreement for which price index data are available.

"(2) The term 'covered drug or biological' means—

"(A) any drug marketed under a new drug application approved by the Secretary of Health and Human Services under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

"(B) any biological marketed under a product licensing application approved by the Administrator of the Food and Drug Administration pursuant to section 351 of the Public Health Service Act (42 U.S.C. 262).

"(3) The term 'depot' means a centralized commodity management system operated by the Department through which drugs and biologicals procured for the use of entities of the Department are—

"(A) received, stored, and delivered through—

"(i) a warehouse system under the jurisdiction and operation of the Department; or

"(ii) a commercial entity operating under contract with the Department; or

"(B) delivered directly from the manufacturer to the entity using the drugs or biologicals.

"(4) The term 'depot price' means the price of a drug or biological under an agreement between the Secretary and the manufacturer of the drug or biological to determine the price of the drug or biological for purchase through depots.

"(5) The term 'Federal average manufacturer price', with respect to a covered drug or biological and a specified period of time, means the weighted average price of a single form and dose unit of the drug or biological that is paid to the manufacturer of the drug or biological, taking into account any cash discounts or similar price reductions, during that period by wholesalers (other than a price paid by the Federal Government).

"(6) The term 'Federal average price differential', with respect to a covered drug or biological whose price is established under an agreement under this subchapter, means—

"(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months—

"(i) the Federal average manufacturer price of the drug or biological during the 3-month period ending on the last day of the last month before the effective date of the agreement for which price data and price index data are available, minus

"(ii) the Federal average manufacturer price of the drug or biological during the 3-month period ending on the date that is 1 year before the ending of such 3-month period; or

"(B) in the case of a drug or biological for which such data does not permit the calculation of that price for as many months—

"(i) the Federal average manufacturer price of the drug or biological during the 3-month period ending on the last day of the last month before effective date of the agreement for which price data and price index data are available, minus

"(ii) the Federal average manufacturer price of the drug or biological during the 3-month period beginning on the first day of the first month next following the month in which marketing of the drug or biological begins.

"(7) The term 'manufacturer', with respect to a drug or biological, means—

"(A) an entity that both manufactures and distributes the drug or biological; or

"(B) if no such entity exists, an entity that distributes the drug or biological.

The term does not include a wholesale distributor of drugs or biologicals, a retail pharmacy licensed under State law, or a practitioner licensed under State law and authorized to dispense drugs or biologicals.

"(8) The term 'price index' means the Producer Price Index—Finished Goods published monthly by the Bureau of Labor Statistics.

"(9) The term 'weighted average price', with respect to a covered drug or biological and a specified period of time, means—

"(A) the sum of the products of—

"(i) the average price per unit of each package quantity of the drug or biological sold during the period, and

"(ii) the number of units of the drug or biological sold at that average price; divided by

"(B) the total number of units of the drug or biological sold during the period.

"§ 8172. Prices of drugs and biologicals under Federal Supply Schedule contracts

"(a)(1) In accordance with the provisions of this section, the Secretary may enter into agreements with the manufacturers referred to in paragraph (2) under which agreements the Secretary and such manufacturers shall provide for the price under the supply schedule of drugs and biologicals that are marketed by such manufacturers.

"(2) The Secretary may enter into agreements under this section with each manufacturer of a drug or biological that enters into a master agreement with the Administrator of the General Services Administration with respect to that drug or biological under section 1001 of the Federal Property and Administrative Services Act of 1949.

"(b) Subject to subsection (g), the price under an agreement under this section of a covered drug or biological that was listed on the supply schedule on September 1, 1990, and is listed on the supply schedule on the date of the enactment of this Act, shall be as follows:

"(1) During the 1-year period beginning on the effective date of the agreement, the price shall be an amount no greater than .76 multiplied by an amount equal to—

"(A) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is positive—

"(i) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary by the manufacturer), minus

"(ii) the additional price discount amount (as determined under section 8171(1)(A) of this title); or

"(B) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based).

"(2) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during such the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

"(d) Subject to subsection (g), the price under an agreement under this section of a covered drug or biological that was not listed on the supply schedule on September 1, 1990, but was approved by the Administrator of the Food and Drug Administration on or before the date of the enactment of this Act, shall be as follows:

"(1) During the 1-year period beginning on the effective date of the agreement—

"(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

"(i) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is positive—

"(I) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary by the manufacturer), minus

"(II) the additional price discount amount (as determined under section 8171(1)(A) of this title); or

"(ii) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based); or

"(B) in the case of a drug or biological for which such data does not permit the calculation of Federal average manufacturer price for as many months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

"(i) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(B) of this title) is positive—

"(I) the Federal average manufacturer price of the drug or biological for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before the effective date of the agreement for which price data are available (as so based), minus

"(II) the additional price discount amount (as determined under section 8171(1)(B) of this title); or

"(ii) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(B) of this title) is not positive, the Federal average manufacturer price of the drug or biological for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before the effective date of the agreement for which price data are available (as so based).

"(2) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during such the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

"(e) Subject to subsection (g), the price under an agreement under this section of a covered drug or biological that is approved by the Administrator of the Food and Drug Administration after the date of the enactment of this Act shall be as follows:

"(1) During the 1-year period beginning on the effective date of the agreement—

"(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

"(i) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is positive—

"(I) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary by the manufacturer), minus

"(II) the additional price discount amount (as determined under section 8171(1)(A) of this title); or

"(ii) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based); or

"(B) in the case of a drug or biological for which such data does not permit the calculation of Federal average manufacturer price for as many months, the price shall be an amount no greater than .76 multiplied by an amount equal to the Federal average manufacturer price of the drug or biological (as so based) for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before such effective date for which such data are available.

"(2) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during such the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

"(f) Subject to subsection (g), the price under an agreement under this section of a covered drug or biological whose price under the supply schedule was determined under subsection (b), (c), (d), or (e), or under this subsection, pursuant to an agreement that is expiring, shall be as follows:

"(1) During the 1-year period beginning on the effective date of the agreement, the price may not exceed the price of the drug or biological under the expiring agreement during the 1-year period beginning on the effective date of the expiring agreement increased by the same percentage as the increase in the price index during the period beginning on the effective date of the expiring agreement and ending on the last day of the last month before the effective date of the agreement under this subsection for which price index data are available.

"(2) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

"(g)(1) In entering into an agreement under subsections (b) through (f) for the price under the supply schedule of a covered drug or biological, the Secretary may provide for a price of a drug or biological during the 1-year period beginning on the effective date of the agreement that is nominally in excess (as determined by the Secretary) of the price that would be determined for the drug or biological during that period under that subsection if the Secretary determines that such excess price is in the best interests of the Department.

"(2) If the Secretary exercises the authority under this section to establish an excess price with respect to the price of a drug or biological during a 1-year period, the determination of the amount of the increase in the price of the drug or biological for the succeeding 1-year period, if any, shall be based on such excess price.

"(h) The price under an agreement under this section of a drug or biological (other than a covered drug or biological) shall be jointly determined by the Secretary and the manufacturer of the drug or biological.

"(i)(1) Except as provided in paragraph (2), the Secretary shall enter into agreements with manufacturers under this section not later than the later of—

"(A) 6 months after the date of the enactment of this section; or

"(B) 30 days after the Secretary notifies the manufacturers of the Secretary's intention to enter into such agreements.

"(2) In the case of a drug or biological that is first marketed after the date that is 5 months after the date of the enactment of this section, the Secretary shall enter into an agreement referred to in paragraph (1) not later than the later of—

"(A) 3 months after the date such marketing begins; or

"(B) 30 days after the Secretary notifies the manufacturer of the Secretary's intention to enter into such an agreement.

"(j) The Secretary shall determine the term of any agreement entered into by the Secretary and a manufacturer under this section.

"§ 8173. Report and audit of prices of drug and biologicals

"(a)(1) The manufacturer of a covered drug or biological whose price is determined by an agreement under section 8172 or 8174 of this title shall report to the Secretary the Federal average manufacturers price of the drug or biological during each calendar quarter in which the agreement is in force. The manufacturer shall report such price not more than 30 days after the expiration of a covered quarter.

"(2) The reports required under paragraph (1) shall be in addition to the reports required under subparagraphs (A)(i) and (B) of subsection (b)(1), subparagraphs (A)(i) and (B) of subsection (c)(1), clauses (i)(I) and (ii) of subsection (d)(1)(A), clauses (i)(I) and (ii) of subsection (d)(1)(B), clauses (i)(I) and (ii) of subsection (e)(1)(A), and subsection (e)(1)(B) of section 8172 of this title, under clauses (i)(I) and (ii) of section 8174(c)(1)(A) of this title, and under subsections (d) and (e) of section 8174 of this title. The reports required under such subparagraphs shall be submitted upon the request of the Secretary.

"(b)(1) The Secretary may impose a civil monetary penalty in an amount equal to $10,000 on any manufacturer that fails to report the information required under paragraph (1) of subsection (a) on a timely basis. Such amount shall be paid to the Treasury. The amount of the penalty shall be increased by $10,000 for each day in which such information has not been reported, and such amount shall be paid to the Treasury. If such information with respect to a drug or biological is not reported within 90 days of the deadline imposed, the Secretary may prohibit the purchase of

the drug or biological through the supply schedule or Department depots after the end of such 90-day period and until the date such information is reported but in no case shall such prohibition be for a period of less than 30 days.

"(2) Any manufacturer that knowingly reports false information to the Secretary under paragraph (1) of subsection (a) or the provisions of law referred to in paragraph (2) of that subsection is subject to a civil monetary penalty in an amount not to exceed $100,000 for each item of false information reported. Such amount shall be paid to the Treasury.

"(3) The civil money penalties described in paragraphs (1) and (2) are in addition to other penalties as may be prescribed by law.

"(c) In order to determine the accuracy of any price of a drug or biological that is reported to the Secretary under the provisions of law referred to in subsection (b)(2), the Secretary may audit—

"(1) the relevant records of any manufacturer of a covered drug or biological that is the subject of an agreement under subsections (b) through (f) of section 8172 or under subsections (c) through (f) of section 8174 of this title; and

"(2) the relevant records of any wholesaler that distributes such a drug or biological.

"(d) All information contained in a report submitted to the Secretary under this section by a manufacturer shall remain confidential.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 81 is amended by adding after the item relating to subchapter V the following new items:

"SUBCHAPTER VI—PROCUREMENT OF DRUGS AND BIOLOGICALS

"8171. Definitions.
"8172. Prices of drugs and biologicals under Federal Supply Schedule contracts.
"8173. Report and audit of prices of drugs and biologicals.".

SEC. 604. PROCUREMENT OF DRUGS AND BIOLOGICALS UNDER CONTRACTS RELATING TO DEPARTMENT OF VETERANS AFFAIRS DEPOTS.

(a) IN GENERAL.—Subchapter VI of chapter 81 (as added by section 603 of this Act) is amended by adding at the end the following new section:

"§ 8174. Procurement of drugs and biologicals through Department depots

"(a) The Secretary shall enter into agreements with manufacturers referred to in section 8172(a)(2) of this title under which agreements the Secretary and such manufacturers shall determine the prices of drugs and biologicals manufactured by such manufacturers and available for purchase through depots of the Department.

"(b) Notwithstanding section 8125(a) of this title, the Secretary may procure for any Department health-care facilities any drug or biological that is subject to an agreement under this section.

"(c)(1) Subject to paragraph (2), the price under an agreement under subsection (a) of a covered drug or biological that was the subject of a contract for procurement by the Department through a depot on September 1, 1990, shall be as follows:

"(A) During the 1-year period beginning on the effective date of the agreement, the price shall be an amount no greater than .76 multiplied by an amount equal to—

"(i) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is positive—

"(I) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary by the manufacturer), minus

"(II) the additional price discount amount (as determined under section 8171(1)(A) of this title); or

"(ii) in the case of a drug or biological whose Federal average price differential is not positive (as determined under section 8171(6)(A) of this title), the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based).

"(B) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period increased by the same percentage as the increase in the price index during the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

"(2)(A) In entering into an agreement under paragraph (1) for the price of a drug or biological, the Secretary may provide for a price of a drug or biological during

the 1-year period beginning on the effective date of the agreement that is nominally in excess (as determined by the Secretary) of the price that would be determined for the drug or biological during that period under that paragraph if the Secretary determines that such excess price is in the best interests of the Department.

"(B) If the Secretary exercises the authority under this section to establish an excess price with respect to the price of a drug or biological during a 1-year period, the determination of the amount of the increase in the price of the drug or biological for the succeeding 1-year period, if any, shall be based on such excess price.

"(d) The price under an agreement under subsection (a) of a covered drug or biological that was not the subject of a contract referred to in subsection (c) on September 1, 1990, but was approved by the Administrator of the Food and Drug Administration on or before the date of the enactment of this Act, shall be determined in the manner set forth for the determination of the price of a drug or biological under section 8172(d) of this title.

"(e) The price under an agreement under subsection (a) of a covered drug or biological that is approved by such Administrator after such date, shall be determined in the manner set forth for the determination of the price of a drug or biological under section 8172(e) of this title.

"(f) The price under an agreement under subsection (a) of a covered drug or biological whose price was determined under subsections (c), (d), or (e), or under this subsection, pursuant to an agreement that is expiring, shall be determined in the manner set forth for the determination of the price of a drug or biological under section 8172(f) of this title.

"(g) The price under an agreement under subsection (a) of a drug or biological (other than a covered drug or biological) shall be jointly determined by the Secretary and the manufacturer of the drug or biological.

"(h)(1) Except as provided in paragraph (2), the Secretary shall enter into agreements with manufacturers under this section not later than the later of—

"(A) 6 months after the date of the enactment of this section; or

"(B) 30 days after the Secretary notifies the manufacturers of the Secretary's intention to enter into such agreements.

"(2) In the case of a drug or biological that is first marketed after the date that is 5 months after the date of the enactment of this section, the Secretary shall enter into an agreement referred to in paragraph (1) not later than the later of—

"(A) 3 months after the date such marketing begins; or

"(B) 30 days after the Secretary notifies the manufacturer of the Secretary's intention to enter into such an agreement.

"(i) The Secretary shall determine the term of any agreement entered into by the Secretary and a manufacturer under this section.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 81 is amended by adding after the item relating to section 8173 (as added by section 603(b) of this Act) the following new item:

"8174. Procurement of drugs and biologicals through Department depots.".

(c) CONFORMING AMENDMENT.—Section 8125(a) is amended by striking out "this section," and inserting in lieu thereof "this section and section 8174(b) of this title,".

SEC. 605. PRICES OF DRUGS AND BIOLOGICALS PROCURED BY STATE HOMES.

(a) IN GENERAL.—Subchapter VI of chapter 81 (as amended by section 604 of this Act), is further amended by adding at the end the following new section:

"§ 8175. Prices of drugs and biologicals purchased by State homes

"In the event that a State home procures a drug or biological listed on the supply schedule, the price of the drug or biological shall be not more than the price of the drug or biological on the supply schedule on the date of the procurement.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 81 is amended by adding after the item relating to section 8174 (as added by section 604(b) of this Act) the following new item:

"8175. Prices of drugs and biologicals purchased by State homes.".

SEC. 606. UNIFIED PHARMACEUTICAL AWARD CONTRACTS.

(a) IN GENERAL.—Subchapter VI of chapter 81 (as amended by section 605 of this Act) is further amended by adding at the end the following new section:

"§ 8176. Unified pharmaceutical award contracts

"(a) The Secretary may, on behalf of the entities referred to in subsection (b), negotiate and enter into one or more unified pharmaceutical award contracts (hereafter in this section referred to as a 'UPAC') with manufacturers relating to the pro-

curement by such entities under such contracts of drugs or biologicals that are manufactured by such manufacturers.

"(b)(1) Subject to paragraph (2), an entity on whose behalf the Secretary may enter into a UPAC under this section is any of the following entities that procures a drug or biological in connection with the furnishing of health-care services:

"(A) A department or agency of the Federal Government, including the Department of Veterans Affairs.

"(B) A department, agency, other division or unit of a State (including a State home), county, or municipality.

"(C) A Public Health Service clinic of the type described in section 2145(a) of the Public Health Service Act which the Secretary of Health and Human Services has certified is eligible to receive a discount under such section 2145.

"(2) The Secretary may not negotiate or enter into a UPAC on behalf of an entity unless the entity enters into an agreement with the Secretary—

"(A) to participate in a UPAC on a basis to be determined by the Secretary;

"(B) to purchase under the UPAC a quantity (as determined by the Secretary) of the drug or biological that is the subject of the UPAC;

"(C) to provide to the Secretary adequate evidence (as determined by the Secretary) of the entity's fiscal capability of making the purchase referred to in subparagraph (B);

"(D) to ensure that the drug or biological purchased through the UPAC is not resold; and

"(E) to pay into the revolving supply fund referred to in section 8121 of this title an amount that the Secretary determines is sufficient to cover any administrative costs of the Secretary in negotiating, entering into, or administering the UPAC.

"(c)(1) An entity on whose behalf the Secretary enters into a UPAC under this section with respect to a drug or biological may not—

"(A) resell or otherwise transfer the drug or biological to a person other than a patient of the entity;

"(B) purchase the drug or biological on behalf of any person or entity other than the entity on whose behalf the Secretary enters into the UPAC; or

"(C) dispense or administer, directly or through a contract, the drug or biological to an individual who is not receiving the drug or biological as a patient of the entity.

"(2)(A) An entity found to have sold, dispensed, or administered a drug or biological in violation of this subsection shall be subject to a civil penalty in the amount of $25,000 for each such violation. Such amount shall be paid to the Treasury.

"(B) The civil money penalty referred to in subparagraph (A) is in addition to any other such penalties as may be prescribed by law.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 81 is amended by adding after the item relating to section 8175 (as added by section 605(b) of this Act) the following new item:

"8176. Unified pharmaceutical award contracts.".

SEC. 607. PROCUREMENT OF DRUGS AND BIOLOGICALS UNDER CONTRACTS RELATING TO DEPARTMENT OF DEFENSE DEPOTS.

(a) IN GENERAL.—Chapter 55 of title 10, United States Code, is amended by adding at the end the following new section:

"§ 1107. Procurement of drugs and biologicals through depots

"(a) IN GENERAL.—(1) The Secretary of Defense may enter into agreements with manufacturers referred to in paragraph (2) under which agreements the Secretary of Defense and such manufacturers shall determine the price of drugs and biologicals manufactured by such manufacturers and available for purchase through depots of the Department of Defense.

"(2) The manufacturers referred to in paragraph (1) are any manufacturers of drugs or biologicals that have entered into an agreement with the Administrator of the General Services Administration with respect to such drugs or biologicals under section 1001 of the Federal Property and Administrative Services Act of 1949.

"(b) PROCUREMENT OF DRUGS AND BIOLOGICALS.—The Secretary of Defense may procure for any facility of the uniformed services any drug or biological that is subject to an agreement under this section.

"(c) PRICES.—(1) Subject to subsection (d), the price under an agreement under this section of a covered drug or biological that was the subject of a contract for procurement by the Department of Defense through a depot on September 1, 1990, shall be as follows:

"(A) During the 1-year period beginning on the effective date of the agreement, the price shall be an amount no greater than .76 multiplied by an amount equal to—

"(i) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(A)) is positive—

"(I) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary of Defense by the manufacturer), minus

"(II) the additional price discount amount (as determined under subsection (h)(1)(A)); or

"(ii) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(A)) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based).

"(B) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period increased by the same percentage as the increase in the price index during the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

"(2) Subject to subsection (d), the price under an agreement under this section of a covered drug or biological that was not the subject of a contract referred to in paragraph (1) on September 1, 1990, but was approved by the Administrator of the Food and Drug Administration on or before the date of the enactment of this Act, shall be as follows:

"(A) During the 1-year period beginning on the effective date of the agreement—

"(i) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

"(I) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(A)) is positive—

"(aa) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary of Defense by the manufacturer), minus

"(bb) the additional price discount amount (as determined under subsection (h)(1)(A)); or

"(II) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(A)) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based); or

"(ii) in the case of a drug or biological for which such data does not permit the calculation of Federal average manufacturer price for as many months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

"(I) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(B)) is positive—

"(aa) the Federal average manufacturer price of the drug or biological for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before the effective date of the agreement for which price data are available (as so based), minus

"(bb) the additional price discount amount (as determined under subsection (h)(1)(B)); or

"(II) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(B)) is not positive, the Federal average manufacturer price of the drug or biological for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before the effective date of the agreement for which price data are available (as so based).

"(B) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during such the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

"(3) Subject to subsection (d), the price under an agreement under this section of a covered drug or biological that is approved by the Administrator of the Food and Drug Administration after the date of the enactment of this Act, shall be as follows:

"(A) During the 1-year period beginning on the effective date of the agreement—

"(i) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

"(I) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(A)) is positive—

"(aa) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary of Defense by the manufacturer), minus

"(bb) the additional price discount amount (as determined under subsection (h)(1)(A)); or

"(II) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(A)) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based); or

"(ii) in the case of a drug or biological for which such data does not permit the calculation of Federal average manufacturer price for as many months, the price shall be an amount no greater than .76 multiplied by an amount equal to the Federal average manufacturer price of the drug or biological (as so based) for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before such effective date for which such data are available.

"(B) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during such the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

"(4) Subject to subsection (d), the price under an agreement under this section of a covered drug or biological whose price was determined under paragraph (1), (2), or (3), or under this paragraph, pursuant to an agreement that is expiring, shall be as follows:

"(A) During the 1-year period beginning on the effective date of the agreement, the price may not exceed the price of the drug or biological under the expiring agreement during the 1-year period beginning on the effective date of the expiring agreement increased by the same percentage as the increase in the price index during the period beginning on the effective date of the expiring agreement and ending on the last day of the last month before the effective date of the agreement under this subsection for which price index data are available.

"(B) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

"(5) The price under an agreement under this section of a drug or biological (other than a covered drug or biological) shall be jointly determined by the Secretary of Defense and the manufacturer of the drug or biological.

"(d) EXCESS PRICE.—(1) In entering into an agreement under paragraphs (1), (2), (3), or (4) of subsection (c) for the depot price of a drug or biological, the Secretary of Defense may provide for a price of a drug or biological during the 1-year period be-

ginning on the effective date of the agreement that is nominally in excess (as determined by that Secretary) of the price that would be determined for the drug or biological during that period under that paragraph if that Secretary determines that such excess price is in the best interests of the Department of Defense.

"(2) If the Secretary of Defense exercises the authority under this subsection to establish an excess price with respect to the price of a drug or biological during a 1-year period, the determination of the amount of the increase in the price of the drug or biological for the succeeding 1-year period, if any, shall be based on such excess price.

"(e) ENTRY INTO AGREEMENTS.—(1) Except as provided in paragraph (2), the Secretary of Defense shall enter into agreements with manufacturers under this section not later than the later of—

"(A) 6 months after the date of the enactment of this section; or

"(B) 30 days after that Secretary notifies the manufacturers of that Secretary's intention to enter into such agreements.

"(2) In the case of a drug or biological that is first marketed after the date that is 5 months after the date of the enactment of this section, the Secretary of Defense shall enter into an agreement referred to in paragraph (1) not later than the later of—

"(A) 3 months after the date such marketing begins; or

"(B) 30 days after that Secretary notifies the manufacturer of that Secretary's intention to enter into such an agreement.

"(f) TERM OF AGREEMENT.—The Secretary of Defense shall determine the term of any agreement entered into by that Secretary and a manufacturer under this section.

"(g) REPORTS ON PRICES.—(1)(A) The manufacturer of a covered drug or biological whose price is determined by an agreement under this section shall report to the Secretary of Defense the Federal average manufacturers price of the drug or biological during each calendar quarter in which the agreement is in force. The manufacturer shall report such price not more than 30 days after the expiration of a covered quarter.

"(B) The reports required under subparagraph (A) shall be in addition to the reports required under clauses (i)(I) and (ii) of subsection (c)(1)(A), subclauses (I)(aa) and (II) of subsection (c)(2)(A)(i), subclauses (I)(aa) and (II) of subsection (c)(2)(A)(ii), subclauses (I)(aa) and (II) of subsection (c)(3)(A)(i), and subsection (c)(3)(A)(ii). The reports required under such subparagraphs shall be submitted upon the request of the Secretary of Defense.

"(2) The Secretary of Defense may impose a civil monetary penalty in an amount equal to $10,000 on any manufacturer that fails to report the information required under paragraph (1) on a timely basis. Such amount shall be paid to the Treasury. The amount of the penalty shall be increased by $10,000 for each day in which such information has not been reported, and such amount shall be paid to the Treasury. If such information with respect to a drug or biological is not reported within 90 days of the deadline imposed, the Secretary of Defense may prohibit the purchase of the drug or biological through the supply schedule or Department depots after the end of such 90-day period and until the date such information is reported but in no case shall such prohibition be for a period of less than 30 days.

"(3) Any manufacturer that knowingly reports false information to the Secretary of Defense under subparagraph (A) of paragraph (1) or the provisions of law referred to in subparagraph (B) of such paragraph is subject to a civil monetary penalty in an amount not to exceed $100,000 for each item of false information reported. Such amount shall be paid to the Treasury.

"(4) The civil money penalties described in paragraphs (2) and (3) are in addition to other penalties as may be prescribed by law.

"(5) In order to determine the accuracy of the price of a covered drug or biological that is reported to the Secretary of Defense under the provisions of law referred to in paragraph (3), the Secretary of Defense may audit—

"(A) the relevant records of any manufacturer of a covered drug or biological that is the subject of an agreement under this section; and

"(B) the relevant records of any wholesaler that distributes such a drug or biological.

"(6) All information contained in a report submitted to the Secretary of Defense under this section by a manufacturer shall remain confidential.

"(h) DEFINITIONS.—In this section:

"(1) The term 'additional price discount amount', in the case of the price of a drug or biological whose price is established under an agreement under this subchapter, means—

"(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months, the amount of the difference, if any, between—

"(i) the Federal average price differential (as determined under paragraph (6)(A)); and

"(ii) the amount equal to—

"(I) the Federal average manufacturer price of the drug or biological for the 3-month period ending on the date that is 12 months before the last day of the last month before the effective date of the agreement for which price index data and price data for the drug or biological are available, multiplied by

"(II) the percentage increase in the price index during that 12-month period; or

"(B) in the case of a drug or biological for which such data does not permit the calculation of that price for as many months, the amount of the difference, if any, between—

"(i) the Federal average price differential (as determined under paragraph (6)(B)); and

"(ii) an amount equal to—

"(I) the Federal average manufacturer price of the drug or biological for the 3-month period beginning on the first day of the month next following the month in which marketing of the drug or biological begins, multiplied by

"(II) the percentage increase in the price index during the period beginning on such day and ending on the last day of the last month before the effective date of the agreement for which price index data are available.

"(2) The term 'covered drug or biological' means—

"(A) any drug marketed under a new drug application approved by the Secretary of Health and Human Services under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

"(B) any biological marketed under a product licensing application approved by the Administrator of the Food and Drug Administration pursuant to section 351 of the Public Health Service Act (42 U.S.C. 262).

"(3) The term 'depot' means a centralized commodity management system operated by the Department of Defense through which drugs and biologicals procured for the use of entities of the Department of Defense are—

"(A) received, stored, and delivered through—

"(i) a warehouse system under the jurisdiction and operation of the Department of Defense; or

"(ii) a commercial entity operating under contract with the Department of Defense; or

"(B) delivered directly from the manufacturer to the entity using the drugs or biologicals.

"(4) The term 'depot price' means the price of a drug or biological under an agreement between the Secretary of Defense and the manufacturer of the drug or biological to determine the price of the drug or biological for purchase through depots.

"(5) The term 'Federal average manufacturer price', with respect to a covered drug or biological and a specified period of time, means the weighted average price of a single form and dose unit of the drug or biological that is paid to the manufacturer of the drug or biological, taking into account any cash discounts or similar price reductions, during that period by wholesalers (other than a price paid by the Federal Government).

"(6) The term 'Federal average price differential', with respect to a covered drug or biological whose price is established under an agreement under this subchapter, means—

"(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months—

"(i) the Federal average manufacturer price of the drug or biological during the 3-month period ending on the last day of the last month before the effective date of the agreement for which price data and price index data are available, minus

"(ii) the Federal average manufacturer price of the drug or biological during the 3-month period ending on the date that is 1 year before the ending of such 3-month period; or

"(B) in the case of a drug or biological for which such data does not permit the calculation of that price for as many months—

"(i) the Federal average manufacturer price of the drug or biological during the 3-month period ending on the last day of the last month before effective date of the agreement for which price data and price index data are available, minus

"(ii) the Federal average manufacturer price of the drug or biological during the 3-month period beginning on the first day of the first month next following the month in which marketing of the drug or biological begins.

"(7) The term 'manufacturer', with respect to a drug or biological, means—

"(A) an entity that both manufactures and distributes the drug or biological; or

"(B) if no such entity exists, an entity that distributes the drug or biological.

The term does not include a wholesale distributor of drugs or biologicals, a retail pharmacy licensed under State law, or a practitioner licensed under State law and authorized to dispense drugs and biologicals.

"(8) The term 'price index' means the Producer Price Index—Finished Goods published monthly by the Bureau of Labor Statistics.

"(9) The term 'weighted average price', with respect to a covered drug or biological and a specified period of time, means—

"(A) the sum of the products of—

"(i) the average price per unit of each package quantity of the drug or biological sold during the period, and

"(ii) the number of units of the drug or biological sold at that average price; divided by

"(B) the total number of units of the drug or biological sold during the period.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 55 of title 10, United States Code, is amended by adding after the item relating to section 1106 the following new item:

"1107. Procurement of drugs and biologicals through depots.".

TITLE VII—MISCELLANEOUS

SEC. 701. PERMANENT AUTHORITY TO FURNISH RESPITE CARE.

Section 1720B is amended by striking out subsection (c).

SEC. 702. EXTENSION OF AUTHORITY TO ENTER INTO CONTRACTS WITH RESPECT TO THE VETERANS MEMORIAL MEDICAL CENTER IN THE PHILIPPINES.

Section 1732(a) is amended in the matter above paragraph (1) by striking out "September 30, 1992," and inserting in lieu thereof "December 31, 1996,".

SEC. 703. PERMANENT AUTHORITY TO WAIVE CERTAIN LIMITATIONS APPLICABLE TO RECEIPT OF RETIREMENT PAY BY NURSES.

Section 7426(c) is amended by striking out the second sentence.

SEC. 704. EXTENSION OF AUTHORITY TO CARRY OUT HEALTH PROFESSIONAL SCHOLARSHIP PROGRAM.

Section 7618 is amended by striking out "September 30, 1992" and inserting in lieu thereof "December 31, 1997".

SEC. 705. PERMANENT AUTHORITY TO MAKE GRANTS TO STATES RELATING TO STATE HOMES.

Section 8133(a) is amended in the first sentence by striking out "through September 30, 1992." and inserting in lieu thereof a period.

Amend the title so as to read:

To amend title 38, United States Code, to revise authorities that apply to nurse pay and to State home facilities, to improve the provision of preventive health services, to provide for a program of mobile health-care clinics, and for other purposes.

Introduction

On April 9, 1992, the Committee's Chairman, Senator Alan Cranston, introduced S. 2575, the proposed "Department of Veterans Affairs Nurse Pay Amendments of 1992," with the cosponsorship of Committee members Dennis DeConcini, Daniel K. Akaka, and Thomas A. Daschle. Senator Graham joined later as a cosponsor. S. 2575 as introduced would have modified VA nurse pay legislation enacted as the Department of Veterans Affairs Nurse Pay Act of 1990 (Public Law 101–366) and extended expiring authorities for certain VA health-care programs.

Earlier, on June 28, 1991, S. 1424 was introduced by Senator Kent Conrad with the cosponsorship of the late Senator Quentin Burdick. S. 1424 would have expanded VA's mobile health-care clinic program. Joining later as cosponsors were Committee members DeConcini, John D. Rockefeller IV, Graham, Akaka, and Daschle, and Senators Harry Reid, Wendell H. Ford, Carl Levin, Howell Heflin, Terry Sanford, Larry Pressler, Slade Gorton, J. James Exon, Lloyd Bentsen, Max Baucus, Timothy E. Wirth, Jeff Bingaman, Herb Kohl, Donald W. Riegle, Jr., Patrick J. Leahy, Richard C. Shelby, Brock Adams, David L. Boren, David Pryor, and Harris Wofford.

On March 19, 1992, S. 2372 was introduced by Senator Cranston with the cosponsorship of the Committee's Ranking Republican Member, Senator Arlen Specter, and Committee members Graham and Daschle. Joining later as cosponsors were Senators Gorton, Adams, John Seymour, Claiborne Pell, Barbara A. Mikulski, and John Glenn. S. 2372 would have provided that compensation received by recipients of VA needs-based pension for their participation in therapeutic work programs at State veterans homes not be considered income for purposes of the VA pension program.

On May 14, 1992, S. 2715 was introduced by Senator Specter with the cosponsorship of Committee member DeConcini. Senator Wofford joined later as a cosponsor. S. 2715 would have established a telephone service demonstration project at two VA health-care facilities.

On May 19, 1992, S. 2740, the proposed "Veterans Preventive Health Act of 1992," was introduced by Senator Cranston with the cosponsorship of Committee members DeConcini, Rockefeller, Graham, and Akaka. S. 2740 would have expanded VA's preventive health programs.

On June 3, 1992, the Committee held a hearing, chaired by Senator Cranston, to receive testimony on S. 1424, S. 2372, S. 2575, and S. 2740. Testimony on these bills was received from the Department of Veterans Affairs Chief Medical Director, Dr. James W. Holsinger, Jr.; Mr. David P. Baine, Director of Federal Health-Care Delivery Issues, U.S. General Accounting Office; and representatives of the American Association of Nurse Anesthetists, the American Nurses Association, the Nurses Association of Veterans Affairs, The American Legion, AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars.

After carefully reviewing the testimony from the foregoing hearing, the Committee met in open session on June 24, 1992, and voted

by a unanimous voice vote to report S. 2575 favorably with an amendment in the nature of a substitute incorporating provisions derived from S. 1424, S. 2372, S. 2740, S. 2575 as introduced, and provisions proposed by Senator Specter relating to the administration of the State Home program. At the June 24, 1992, markup the Committee also approved by a unanimous voice vote an amendment offered by Senator Cranston, derived from S. 1424 and modified by a second degree amendment offered by Senator Simpson, regarding VA rural health-care clinics and approved by a vote of 8 to 3 an amendment offered by Senators Specter and DeConcini, derived from S. 2715, regarding telephone service in VA patient rooms. At the Committee's August 7, 1992, the Committee approved by voice vote, with Senator Specter expressly abstaining, an amendment offered by Senators Rockefeller, Simpson, Murkowski, and Cranston regarding VA prices for pharmaceuticals. The Committee also approved by unanimous consent an additional amendment offered by Senator Cranston regarding the State Home program.

Summary of S. 2575 as Reported

S. 2575 as reported (hereinafter referred to as the "Committee bill") consists of seven titles summarized below.

TITLE I—NURSE PAY

Title I contains freestanding provisions and amendments to title 38 that would:

Section 101

1. Replace the current four-grade Department of Veterans Affairs nurse pay schedule with a schedule of five grades, designated Nurse I through Nurse V.

Section 102

2. Authorize the Secretary of Veterans Affairs to establish and adjust the rates of basic pay for employees in covered positions at the Veterans Memorial Medical Center in the Philippines and the VA Medical Center in San Juan, Puerto Rico, and its satellite facilities in order to provide rates of pay necessary to recruit and retain sufficient numbers of qualified employees at those facilities.

Section 103

3. Authorize the Secretary to permit the director of a VA health-care facility, in conducting a local wage survey for purposes of the VA locality-pay system for certain health-care personnel, to use, in accordance with regulations prescribed by the Secretary, data on (a) beginning rates of compensation for employees in comparable positions at non-VA facilities in a comparable, but not geographically coterminous, labor-market area, if the director demonstrates that sufficient data cannot be obtained within the local labor-market area to establish competitive salaries; and (b) compensation received by certified registered nurse anesthetists (CRNAs) employed in salaried positions by firms that provide anesthesia services on a contract basis within the local labor-market area, if the

director demonstrates that data on salaries paid to CRNAs employed by health-care facilities in that are not sufficient to establish competitive salary rates.

Section 104

4. Require the director of a VA health-care facility to include in the survey on which locality pay is to based the minimum rates of pay actually paid to—rather than established for—employees in covered positions by non-VA facilities in the local labor-market area.

Section 105

5. (a) Authorize the Secretary to increase the rate of basic pay of an employee in a position covered by locality pay who transfers, upon the request of the Secretary (not including an employee transferred as a result of disciplinary action), to a comparable or more responsible position at a VA health-care facility at which the rate of pay for the position is lower than that paid for such a position at the VA facility from which the employee transferred; and (b) require the Secretary to include information on the use of this transferred-employee pay authority in the annual report to Congress on the implementation of the Department of Veterans Affairs Nurse Pay Act of 1990.

TITLE II—PREVENTIVE HEALTH CARE

Title II contains freestanding provisions and amendments to title 38 that would:

Section 203

1. Require the Chief Medical Director (CMD) to establish within the Veterans Health Administration (VHA) a National Center for Preventive Health Care (Center).

2. Require the Director of the Center to acquire, maintain, and disseminate current information on VA and non-VA clinical practices and research concerning preventive health services; monitor implementation of the recommendations of the Preventive Health Services Advisory Committees; facilitate cooperative research concerning health outcomes resulting from various preventive services; advise VA health-care personnel regarding the conduct of preventive health services activities and research; and issue annual reports regarding VA's preventive health services activities and research findings.

Section 203

3. Authorize the appropriation of $2,500,000 annually to fund the Center's research, clinical, educational, and administrative activities and specify that the costs of the Center be paid from VA's Medical Care account.

Section 204

4. Require the Secretary to establish a Preventive Health Advisory Committee (Advisory Committee) whose members would be appointed by the Secretary upon the recommendation of the CMD.

Members would be non-VA employees who have demonstrated interest and expertise in research, education, and clinical activities related to the provision of preventive health services, including both persons who are and who are not employees for the federal government and representatives of veterans who receive health services from VA.

Section 204

5. Require the Advisory Committee to advise the Secretary, through the EMD, regarding general developments in preventive health services research and clinical activities, as well as the initiation, enhancement, modification, and discontinuation of the furnishing of specific preventive health services; respond to request of the Secretary or the CMD for information on specific research and clinical activities; and submit to the Secretary, through the CMD, an annual report and any other reports the Committee considers appropriate.

Section 204

6. Require the Secretary, (a) in the case of an Advisory Committee report other than the Advisory Committee's annual report, to transmit the report, together with the Secretary's comments and recommendations, to the appropriate Committees of the Congress not later than 90 days after receipt of a report from the Advisory Committee, and (b) in the case of the Advisory Committee's annual report, to transmit that report to the Committees on Veterans' Affairs of the Senate and House of Representatives as part of the Secretary's annual report to the Committees under section 205.

Section 205

7. Require the Secretary to submit to the Committees on Veterans' Affairs of the Senate and House of Representatives an annual report that would include information concerning the types of preventive health services furnished by VA, the resources used to furnish those services, and the number of veterans furnished such services; the means by which VA addressed the specific preventive health services needs of particular groups of veterans; the coordination of the furnishing of preventive health services within VA; the integration of preventive health services into VA training programs for health-care professionals; VA's participation in cooperative preventive health efforts with other governmental and nongovernmental entities; specific VA research concerning the long-term relationships among screening activities, treatment, and morbidity and mortality outcomes; the cost effectiveness of specific preventive health services; preventive health services research carried out by VA employees or using VA funds, equipment, office space space, or other support services; the membership, activities, and report of the Advisory Committee; and an accounting of the expenditure of funds by the Center.

Section 201

8. Revise the definition of the preventive health services that VA is authorized to furnish to include expressly periodic medical and dental examinations (including screening for high blood pressure,

glaucoma, high cholesterol, and colorectal and gender-specific cancers), and patient health education (including education relating to nutrition, stress management, physical fitness, and stopping smoking).

TITLE III—STATE HOME FACILITIES

Title III of the Committee bill contains freestanding provisions and amendments to title 38 that would:

Section 301

1. Amend section 1718 of title 38 to add a new subsection (g) that would: First, clarify that neither a veteran's participation in a State home incentive therapy (IT) or compensated work therapy (CWT) program that the Secretary approves as conforming to VA standards, nor a veteran's receipt of payment for participating in such a program may be used as a basis for denying or discontinuing a rating of total disability on the basis of unemployability, and second, provide that a payment to a veteran participating in an approved State home IT or CWT program be considered to be a donation form a public or private relief organization.

Section 302

2. Extend from 90 days to 180 days the period, following conditional approval of a State's application for State Home Program funds, within which a State must meet all requirements for participation in the State Home Program.

Section 303

3. Prohibit the obligation of funds for a State Home project until the beginning of the next fiscal year if a State fails to complete all requirements for participation in the State Home Program within the conditional-approval period.

Section 304

4. Specify that the 20-year period during which VA may "recapture" funds for a facility no longer used as a State Home begins on the date on which the final architectural and engineering inspection is completed.

Section 305

5. Allow the Secretary to pay to States per diem rates for the care of veterans in State veterans homes for the time period between the recognition inspection and the notification of recognition retroactivity after the issuing of the official recondition notification.

TITLE IV—RURAL HEALTH—CARE CLINICS

Title IV contains freestanding provisions and amendments to title 38 that would:

Section 401

1. Require VA, during the three-year period beginning on October 1, 1992, to conduct a rural health-care clinic program in States

in which significant numbers of veterans reside in areas geographically remote from existing health-care facilities, as determined by the Secretary.

Section 401

2. Require VA to conduct the program through the use of (a) mobile health-care clinics equipped, operated, and maintained by VA personnel, and (b) part-time stationary clinics operated by VA personnel and through contracts with non-VA entities.

Section 401

3. Require VA to furnish health-care services through the program at locations at least 100 miles from the nearest VA health-care facility, or in areas less than 100 miles from the nearest VA health-care facility which the Secretary determines to be appropriate for the furnishing of health-care services through the program.

Section 401

4. Extend eligibility to receive health-care services through the program to all veterans who are eligible for VA health-case services under chapter 17 of title 38.

Section 401

5. Require VA to begin operating at least three rural health-care clinics, at least one of which must be a mobile health-care clinic, during each of the three fiscal years of the program.

Section 401

6. Prohibit VA from operating as part of the program more than one rural health-care clinic in any State.

Section 401

7. Require the Secretary, not later than December 31, 1996, to submit to Congress a report on the program.

Section 401

8. Authorize appropriations of $3 million in FY 1993, $6 million in FY 1994, and $9 million in FY 1995 for the rural health-care clinic program and prohibit the expenditure of funds for the program unless expressly appropriated for that purpose.

TITLE V—TELEPHONE USE DEMONSTRATION PROJECT

Title V contains freestanding provisions that would:

Section 501

Require VA to (a) establish, at the VA Medical Centers in Philadelphia, Pennsylvania, and Tucson, Arizona, demonstration projects on bedside telephone installations for the purpose of determining the feasibility and desirability of telephone installations in patients' rooms in VA health-care facilities; (b) ensure that costs associated with long-distance telephone calls are borne by patients making such calls; (c) evaluate (1) the costs of installing, using and maintaining equipment (including special equipment for the dis-

abled), (2) the savings generated by patient access to telephone service (including savings attributable to the freeing of staff from the burden of assisting patients in making and receiving calls), and (3) the positive therapeutic effects of ready access to telephone service; (d) report to the Committees on Veterans' Affairs of the Senate and the House of Representatives, not later than September 30, 1994, on VA's findings with respect to the demonstration projects and include in the report information regarding (1) VA's determinations with respect to costs, savings, and positive therapeutic effects of the demonstration project, and (2) VA's assessment with respect to the feasibility and desirability of national telephone installations.

TITLE VI—PROCUREMENT OF PHARMACEUTICALS

Title VI contains amendments to titles 10, 38, and 41 of the United States Code that would:

Section 602

1. (a) Require a manufacturer of a drug or biological, not later than five months after the date of enactment—as a condition of (1) selling the drug or biological to a Federal agency (the Department of Veterans Affairs (VA), the Department of Defense (DoD), or the Public Health Service (PHS)); (2) receiving payment for the drug or biological under the Medicaid program; and (3) receiving payment for the drug or biological directly or indirectly from any entity that receives funds under the Public Health Service Act—to enter into a master agreement with the Administrator of the General Services Administration (GSA) under which the manufacturer must agree to enter into Federal Supply Schedule (FSS), VA depot, and DoD depot pharmaceutical pricing agreements (described below); (b) require the manufacturer to enter into FSS, VA depot, and DoD depot pricing agreements for a drug or biological within six months of the date of enactment, or, if the Secretary of Veterans Affairs or Defense does not desire to enter into such an agreement during that time period, within 30 days after the Secretary makes a request to enter into a pricing agreement; (c) require that prices charged to a Federal agency under FSS, VA depot, or DoD depot pharmaceutical pricing agreements be established in accordance with the provisions of the Committee bill; (d) require that the Administrator of GSA prescribe procedures under which the Secretary of Veterans Affairs or Defense must notify a manufacturer of the Secretary's desire to enter into an FSS, VA depot, or DoD depot pharmaceutical pricing agreement; (e) with respect to a drug or biological first marketed after the date of enactment, require the manufacturer (1) within two months after the date on which such marketing begins (A) if the manufacturer has previously entered into a master agreement with the Administrator of GSA, to amend that agreement to cover the new drug or biological, or (B) if the manufacturer has not previously entered into a master agreement, to enter into one, and (2) to enter into FSS, VA depot, and DoD depot pharmaceutical pricing agreements within three months after the drug or biological is first marketed or, if the Secretary of Veterans Affairs or Defense does not desire to enter into such an

agreement during that time period, within 30 days after the Secretary makes a request to enter into such a pricing agreement.

Section 603

2. Define "covered drug or biological" as any biological marketed under a product licensing application approved by the Administrator of FDA or any drug marketed under a new drug application approved by FDA and provide that prices for such drugs and biologicals procured through the FSS be determined as follows: (a) in the case of drug or biological that was on the FSS on September 1, 1990, an amount no greater than 76 percent of the Federal average manufacturer price (FAMP) for the drug or biological during the most recent 12-month period prior to the effective date of a new FSS agreement for which FAMP data are available minus, in the case of a drug or biological for which the FAMP has increased during that 12-month period, the additional price discount amount (the amount by which, if any, the increase in the FAMP during that period exceeds the increase in the Producer Price Index-Finished Goods during that period); (b) in the case of a drug or biological that was not on FSS on September 1, 1990, but was approved for marketing by the Administrator of the Food and Drug Administration (FDA) prior to the date of enactment of the Committee bill, an amount no greater than 76 percent of the FAMP for the drug or biological during (1) the most recent 12-month period prior to the effective date of a new FSS agreement for which FAMP data are available, minus, in the case of a drug or biological for which the FAMP has increased during the applicable period, the additional price discount amount, or (2) where the FAMP cannot be calculated for the 15 months prior to the effective date of the agreement, the period beginning on the date on which marketing of the drug or biological begins and ending on the effective date of the agreement, minus, in the case of a drug or biological for which the FAMP has increased during the applicable period, the additional price discount amount; (c) for a drug or biological that is approved for marketing by FDA after the date of enactment of this Act, an amount no greater than 76 percent of the FAMP for the drug or biological during (1) the most recent 12-month period prior to the effective date of a new FSS agreement for which FAMP data are available, minus, in the case of a drug or biological for which the FAMP has increased during the applicable period, the additional price discount amount, or (2) where the FAMP cannot be calculated for the 15 months prior to the effective date of the agreement, the period beginning on the date on which marketing of the drug or biological begins and ending on the effective date of the agreement; (d) authorize the Secretary of Veterans Affairs to negotiate a price that is nominally higher, as determined by the Secretary, than the FSS price that would otherwise be established for that covered drug or biological under the mechanisms established under the Committee bill, if the Secretary determines that such excess price is in the best interests of VA; (e) provide, in the case of a multi-year FSS agreement, that the price of a drug or biological may be increased on an annual basis by a percentage no greater than the increase in the Producer Price Index-Finished Goods during the preceding year; (f) provide that a price negotiated under a subsequent FSS

agreement would not exceed the price for the drug or biological on the effective date of the expiring agreement increased by the percentage increase in the Producer Price Index-Finished Goods from the effective date through the expiration date of the expiring agreement; (g) with regard to data on the Federal average manufacturer price (FAMP) of a drug or biological (1) require manufacturers to report FAMP data to the Secretary of Veterans Affairs, in a manner determined by the Secretary (A) before entering into an FSS (or VA depot) pricing agreement, for the 12-month period prior to the effective date of such an agreement, and (B) not more than 30 days after the end of the previous calendar quarter for each calendar quarter in which the FSS (or VA depot) agreement is in force, (2) authorize the Secretary of Veterans Affairs to impose civil monetary penalties on manufacturers that fail to report data on their FAMPs in a timely fashion or that report false information, (3) authorize the Secretary to audit the relevant records of (A) the manufacturer of a drug or biological covered by an FSS (or VA depot) contract to determine the accuracy of FAMP data reported to the Secretary by the manufacturer, and (B) any wholesaler that distributes that drug or biological, and (4) provide for FAMP data transmitted by manufacturers to the Secretary to remain confidential.

Section 603

3. Provide for the Secretary to negotiate with manufacturers to establish FSS prices for generic and nonprescription drugs and biologicals.

Section 606

4. (a) Provide that prices for covered drugs and biologicals procured through VA depots be determined as follows: (1) in the case of a drug or biological that was procured by VA through a VA depot on September 1, 1990, an amount no greater than 76 percent of the FAMP for the drug or biological during the most recent 12-month period prior to the effective date of a new FSS agreement for which FAMP data are available minus, in the case of a drug or biological for which the FAMP has increased during the 12-month period, the additional price discount amount (the amount by which, if any, the increase in the FAMP during that period exceeds the increase in the Producer Price Index-Finished Goods during that period); (2) in the case of a drug or biological that was not procured by VA through a VA depot on September 1, 1990, but was approved for marketing by the FDA prior to the date of enactment of the Committee bill, an amount no greater than 76 percent of the FAMP for the drug or biological during (A) the most recent 12-month period prior to the effective date of a new FSS agreement for which FAMP data are available, minus, in the case of a drug or biological for which the FAMP has increased during the applicable period, the additional price discount amount, or (B) where the FAMP cannot be calculated for the 15 months prior to the effective date of the agreement, the period beginning on the date on which marketing of the drug or biological begins and ending on the effective date of the agreement, minus, in the case of a drug or biological for which the FAMP has increased during the applicable

period, the additional price discount amount; (3) for a drug or biological that is approved for marketing by FDA after the date of enactment of this Act, and amount no greater than 76 percent of the FAMP for the drug or biological during (A) the most recent 12-month period prior to the effective date of a new FSS agreement for which FAMP data are available, minus, in the case of a drug or biological for which the FAMP has increased during the applicable period, the additional price discount amount, or (B) where the FAMP cannot be calculated for the 15 months prior to the effective date of the agreement, the period beginning on the date on which marketing of the drug or biological begins and ending on the effective date of the agreement; (b) authorize the Secretary of Veterans Affairs to negotiate a price that is nominally higher, as determined by the Secretary, than the depot price that would otherwise be determined for that single source or innovator multiple source drug or biological, if the Secretary determines that such excess price is in the best interests of VA; (c) provide for the Secretary to negotiate with manufacturers to establish prices for generic and nonprescription drugs; (d) provide, in the case of a multi-year depot agreement, that the price of a drug or biological may be increased on an annual basis by a percentage no greater than the increase in the Producer Price Index-Finished Goods during the preceding year; (e) provide that a price negotiated under a subsequent depot price agreement would not exceed the price for the drug or biological on the effective date of the expiring depot price agreement increased by the percentage increase in the Producer Price Index-Finished Goods from the effective date through the expiration date of the expiring agreement.

Section 605

5. Provide that, when a State Veterans Home purchases drugs and biologicals which are listed on the FSS, the prices paid by such home shall be no greater than FSS prices.

Section 606

6. (a) Authorize VA to negotiate and enter into pharmaceutical contracts, to be known as Unified Pharmaceutical Award Contracts (UPACs), on behalf of (1) governmental entities, including State Veterans Homes and other federal, State, county, and municipal health-care programs, and (2) certain Public Health Service-funded clinics; (b) require an entity which desires to participate in a UPAC to (1) enter into an agreement with VA on a basis to be determined by the Secretary, to participate in a UPAC, (2) make a commitment to purchase a certain quantity of the drug or biological during the UPAC contract period, (3) provide adequate proof of fiscal capability to meet the purchase volume commitment, (4) provide reasonable evidence that the drug will not be diverted to for-profit sales, and (5) pay to VA's revolving supply fund a contract user fee to offset VA's administrative costs relating to UPACs; (c) authorize the Secretary to determine, for each UPAC agreement, which governmental entities will participate in the UPAC; (d) authorize the Secretary to impose civil monetary penalties on any governmental entity that diverts to for-profit sales any drug or biological procured through a UPAC agreement.

Section 607

7. Define "covered drug or biological" as any biological marketed under a product licensing application approved by the Administrator of FDA or any drug marketed under a new drug application approved by FDA and (a) provide that prices for single source and innovator multiple source drugs and biologicals procured through DoD depots be determined as follows: (1) in the case of drug or biological that was procured by DoD through a DoD depot on September 1, 1990, an amount no greater than 76 percent of the FAMP for the drug or biological during the most recent 12-month period prior to the effective date of a new FSS agreement for which FAMP data are available minus, in the case of a drug or biological for which the FAMP has increased during the 12-month period, the additional price discount amount (the amount by which, if any, the increase in the FAMP during that period exceeds the increase in the Producer Price Index-Finished Goods during that period), (2) in the case of a drug or biological that was not procured by DoD through a DoD depot on September 1, 1990, but was approved for marketing by FDA prior to the date of enactment of the Committee bill, an amount no greater than 76 percent of the FAMP for the drug or biological during (A) the most recent 12-month period prior to the effective date of a new FSS agreement for which FAMP data are available, minus, in the case of a drug or biological for which the FAMP has increased during the applicable period, the additional price discount amount, or (B) where the FAMP cannot be calculated for the 15 months prior to the effective date of the agreement, the period beginning on the date on which marketing of the drug or biological begins and ending on the effective date of the agreement, minus, in the case of a drug or biological for which the FAMP has increased during the applicable period, the additional price discount amount; (3) for a drug or biological that is approved for marketing by FDA after the date of enactment of this Act, an amount no greater than 76 percent of the FAMP for the drug or biological during (A) the most recent 12-month period prior to the effective date of a new FSS agreement for which FAMP data are available, minus, in the case of a drug or biological for which the FAMP has increased during the applicable period, the additional price discount amount, or (B) where the FAMP cannot be calculated for the 15 months prior to the effective date of the agreement, the period beginning on the date on which marketing of the drug or biological begins and ending on the effective date of the agreement; (b) authorize the Secretary of Defense to negotiate a price that is nominally higher, as determined by the Secretary, than the depot price that would otherwise be established for that covered drug or biological, if the Secretary determines that such excess price is in the best interests of DoD; (c) provide for the Secretary to negotiate with manufacturers to establish prices for generic and nonprescription drugs and biologicals; (d) provide, in the case of a multi-year DoD depot agreement, that the price of a drug or biological may be increased on an annual basis by a percentage no greater than the increase in the Producer Price Index-Finished Goods during the preceding year; (e) provide that a price negotiated under a subsequent DoD depot agreement would not exceed the price for

the drug or biological on the effective date of the expiring agreement increased by the percentage increase in the Producer Price Index-Finished Goods from the effective date through the expiration date of the expiring agreement; (f) with regard to data on the FAMP of a drug or biological (1) require manufacturers to report FAMP data to the Secretary of Defense, in a manner determined by the Secretary (A) prior to entering into a DoD depot pricing agreement, for the 12-month period prior to the effective date of such an agreement, and (B) not more than 30 days after the end of the previous calendar quarter for each calendar quarter in which the DoD depot agreement is in force, (2) authorize the Secretary of Defense to impose civil monetary penalties on manufacturers that fail to report data on their FAMPs to the Secretary in a timely fashion or that report false information, (3) authorize the Secretary of Defense to audit the relevant records of (A) the manufacturer of a drug or biological covered by a DoD depot contract to determine the accuracy of FAMP data reported by the manufacturer, and (B) any wholesaler that distributes that drug or biological, and (4) provide for FAMP data transmitted by manufacturers to the Secretary to remain confidential.

TITLE VII—MISCELLANEOUS

Title VII of the Committee bill contains amendments to title 38 that would:

Section 701

1. Make permanent VA's authority to furnish respite care to veterans eligible to receive VA hospital, nursing home, or domiciliary care.

Section 702

2. Extend for four years and three months, through December 31, 1996, VA's authority to enter into contracts with the Veterans Memorial Medical Center in the Philippines for the United States to provide for payments for hospital care and medical services to eligible U.S. veterans.

Section 703

3. Make permanent VA's authority to waive the restrictions on receipt of military retirement pay contained in section 5532 of title 5 if necessary to meet special or emergency needs for registered nurses resulting from a critical shortage of well-qualified candidates.

Section 704

4. Extend for five years and three months, through December 31, 1997, the authority for the Department of Veterans Affairs Health Professional Scholarship Program.

Section 705

5. Make permanent VA's authority to make grants to States for the construction or renovation of state veterans homes.

Discussion

TITLE I—NURSE PAY

Background

As the largest health-care system in the United States, employing over 35,000 nurses, VA experiences to a magnified degree the difficulties that the Nation's health-care facilities face in nurse recruitment and retention. These difficulties are caused by a number of factors, including a dramatic decline in enrollment in nursing schools during the 1980's, increasing use of complicated technology which requires advanced training, and increasing administrative burdens on nurses resulting from cutbacks in clerical personnel. Recent increases in nursing school enrollment and unemployment rates have combined to mitigate VA's registered nurse (RN) recruitment and retention difficulties but by no means have eliminated them.

Once VA's nurse recruitment and retention difficulties became apparent in the late 1980's, the House and Senate Committees on Veterans' Affairs began working on legislation to improve VA's ability to recruit and retain adequate numbers of highly-qualified RNs and certified registered nurse anesthetists (CRNAs). Those efforts culminated in the enactment of the Department of Veterans Affairs Nurse Pay Act of 1990, Public Law 101–366 (hereinafter referred to as the Nurse Pay Act), on August 15, 1990. The Act replaced VA's national salary schedule for RNs and CRNAs with a locality-pay system under which salaries for RNs and CRNAs at each VA health-care facility are established in relation to salaries and other benefits provided to RNs and CRNAs by non-VA health-care facilities in the same local labor-market area. The Act also authorized VA to establish locality pay systems for certain additional health-care occupations.

Overall, the Act appears to have been a success. Since its implementation in April 1991, recruitment and retention of RNs and CRNAs has improved significantly at many VA health-care facilities. As is often the case with new endeavors, however, some problems persist. For example, officials at individual VA health-care facilities made a number of serious errors in conducting surveys of salaries paid by non-VA facilities in their local labor-market areas prior to the effective date of the new salary rates. Many of these errors have been corrected and VA officials believe that the second round of local labor-market surveys—conducted in December 1991—generally yielded more accurate results. However, certain widespread complaints about the survey process appeared to be attributable to the legislation itself or to VA's implementing regulations rather than administrative errors. In addition, hundreds of RNs and CRNAs have called or written to Committee members and other Senators to express concerns regarding certain of the Nurse Pay Act's provisions.

To address these concerns, Committee staff met with VA officials and with members and staff of organizations representing VA RNs and CRNAs, including the Nurses Organization of Veterans Affairs, the Association of VA Nurse Anesthetists, the American Association of Nurse Anesthetists, and the American Nurses Associa-

tion. Chairman Cranston, Ranking Republican Member Specter, and other Committee members also wrote to VA Secretary Edward J. Derwinski on numerous occasions to request his views in response to complaints from individual RNs and CRNAs. In general, the Secretary and other VA officials have been quite responsive to Congressional inquiries regarding the implementation of the Nurse Pay Act and the Committee appreciates their efforts in this regard.

Sensing a need for a comprehensive, objective analysis of VA's efforts to implement the Act, Senators Cranston and Specter wrote to the Comptroller General on October 29, 1991, to request that the General Accounting Office evaluate VA's implementation of the Act. In August 1991, Secretary Derwinski established a task force composed of VA Nursing Service and personnel officials and representatives from VA health-care facilities to review the implementation of the Act and formulate recommendations for its improvement.

GAO evaluators presented their preliminary findings to the Committee in mid-February, testified at the Committee's June 3, 1992, hearing and expect to complete a final report later this year. On January 30, 1992, Secretary Derwinski released a list of the VA task force's suggestions for improving the legislation and VA's implementing regulations. VA officials are presently evaluating these suggestions to determine what further action VA will take or propose.

The preliminary findings of both GAO and the VA Nurse Pay Task Force confirmed many of the RNs and CRNAs' complaints and indicated that improvements need to be made in both the legislation and VA's implementing regulations. For example, with respect to VA regulations, GAO found that VA did not fully utilize Bureau of Labor Statistics methods for surveying salaries paid to employees in covered positions at non-VA health-care facilities in local labor-market areas. In addition, a lack of Central Office guidance regarding RN and CRNA participation in data collection led to wide variations in their participation. At some VA health-care facilities, RNs and CRNAs had little or no opportunity to consult with personnel administrators regarding the survey process. Lack of RN and CRNA participation at these facilities appears to have contributed to the collection of inaccurate data on salaries paid by non-VA health-care facilities and, hence, contrary to the goals of the legislation, to the establishment of inadequate salary rates.

The Committee is quite concerned about the problems RNs and CRNAs are experiencing with the survey process. However, the Committee notes that, in the main, these problems are regulatory rather than legislative in nature and, thus, are not addressed directly in S. 2575. The Committee is continuing to work with VA officials and organizations representing VA RNs and CRNAs to resolve these problems.

Committee bill

Additional nurse pay grade

The Nurse Pay Act replaced the existing system of eight pay grades for RNs with a system of four pay grades that were designated as director, senior, intermediate, and entry grades. Soon

after the new four-grade system was implemented, the Committee began to receive reports that RNs in the upper steps of the intermediate and senior grade were experiencing what has been termed "pay compression". Because the conversion from an eight- to a four-grade system reduced the total number of pay levels within the nurse pay schedule, it reduced the number of opportunities an RN would have for salary increases and limited VA's ability to make salary distinctions among RNs with various qualifications and responsibilities. Many RNs view the reduction in the number of opportunities for salary increases as a loss of potential earnings. Some RNs argued that pay compression would discourage experienced RNs from remaining in clinical positions—despite the fact that encouraging them to do so had been one of the main goals of the Nurse Pay Act. In addition, under the four-grade system, RNs with disparate responsibilities are more likely to be assigned to the same step within a grade, a situation which may have a detrimental impact on morale at VA health-care facilities. For example, at some VA health-care facilities an experienced head nurse may earn a salary equal to or higher than the salary of an Assistant Chief Nurse with fewer years of service, despite the fact that the Assistant Chief Nurses are generally responsible for supervision of head nurses.

To a large extent, these concerns appear to reflect an unfortunate side effect of the establishment of a flexible pay system designed to produce salaries comparable to those paid by non-VA facilities. The Nurse Pay Act ensures that no RN who remains in the same position at the same VA facility will receive a salary lower than the salary she or he received on the effective date of the Act. However, because salary increases are determined in accordance with changes in prevailing conditions in local labor-market areas, the Nurse Pay Act does not guarantee that RNs' salaries will increase as rapidly and as significantly as they had under the eight-grade system.

The Committee maintains its view that a flexible, market-driven, locally-competitive pay system enhances VA's ability to recruit and retain highly-qualified RNs. However, the Committee recognizes the severity of the pay compression problem, especially among the approximately 27,000 RNs serving in intermediate grade positions.

Section 101 of the Committee bill would enable VA to relieve the pay compression experienced by RNs in the intermediate and senior grades by replacing that four-grade system with a system of five grades numbered I through V. An additional grade for RN positions would establish additional pay levels in the nurse schedule that would allow for more equitable distinctions in rates of compensation paid to an extensive range of clinical and supervisory nurses. The Committee expects VA to revise the qualification standards for the various grades to accomplish that purpose. Further, the Committee recommends that such revisions provide for a distribution of RNs throughout the pay system's five grades which does not result in two-thirds of all RNs serving in positions in one of the five grades, as is the case at present with regard to the intermediate grade.

Rates of pay at the Veterans Memorial Medical Center in Manila and the San Juan VAMC:

Section 102 of the Committee bill would authorize the Secretary to establish and adjust the rates of basic pay for employees in covered positions at the Veterans Memorial Medical Center in the Philippines and the VA Medical Center in San Juan, Puerto Rico, in order to provide rates of pay necessary to recruit and retain sufficient numbers of employees at these facilities. Because salaries paid by non-Federal health-care facilities in Manila and San Juan are so much lower than those paid by VA under the systemwide nurse salary schedule in effect prior to enactment of the VA Nurse Pay Act of 1990, exemption from the locality-pay system established under that Act is necessary to ensure that these facilities continue to recruit and retain highly-qualified RNs and CRNAs. For example, VA personnel officials believe that unless legislation such as section 102 is enacted many RNs employed by the San Juan VAMC will seek to transfer to VA medical centers in areas of the continental United States with high concentrations of Puerto Ricans, such as Miami and New York, because salaries at those VAMCs would be much higher than those paid by the San Juan VAMC. The Committee anticipates that such an exemption would likely be necessary for other occupations for which VA is authorized to implement locality pay. The provision also would apply to any VA health-care facility that may be established in the future outside the continental United States, Alaska, and Hawaii.

Importation of data from comparable labor market areas

Section 103 of the Committee bill would authorize the Secretary to permit the director of a VA health-care facility, in conducting a survey to establish locally competitive rates of pay for covered positions, to use data on beginning rates of compensation for employees in comparable positions at non-VA facilities in comparable, but not geographically coterminous, labor-market areas. Directors of some VA health-care facilities, primarily facilities in rural areas, have experienced difficulty in obtaining sufficient data to establish competitive salaries, because their facilities are located in labor-market areas in which a very small number of non-VA facilities are located or in which no non-VA facilities employ personnel in certain covered positions. The ability to use data on salaries paid by non-VA facilities in comparable labor-market areas would give the directors of such facilities an additional tool to use in establishing appropriate salary rates. Use of this authority would be contingent upon a director's ability to demonstrate, in accordance with regulations prescribed by the Secretary, that sufficient data could not be obtained on salaries paid by non-VA facilities within the local labor-market area in which a VA health-care facility is located.

Use of data on salaries paid to CRNAs by anesthesia contractors

Section 103 also would authorize the director of a VA health-care facility to use, in accordance with regulations prescribed by the Secretary, data on compensation received by CRNAs employed on a salary basis by entities that provide anesthesia services on a con-

tract basis within the local labor-market area, if the director demonstrates that data on salaries paid to CRNAs employed by health-care facilities in that area are not sufficient to establish competitive salary rates.

CRNAs have criticized the Nurse Pay Act because it requires VA to survey only salaries paid by non-VA health-care facilities in local labor-market areas. CRNAs have pointed out that many non-VA health-care facilities do not employ CRNAs but instead obtain their services through arrangements with firms that provide anesthesia services on a contract basis. In local labor-market areas in which non-VA health-care facilities typically obtain CRNA services through contracts with these firms, anesthesia contractors compete directly with VA facilities for CRNAs. By authorizing VA facility directors to survey compensation paid to CRNAs employed by anesthesia contractors on a salary basis, section 103 would enable VA facility directors in such local labor-market areas to better establish locally competitive rates of pay for CRNAs.

The requirement that VA survey only compensation paid to CRNAs employed by anesthesia contractors on a salary basis reflects the Committee's effort to respond to concerns raised by VA officials at the Committee's June 3, 1992, hearing. At the hearing, Deputy Assistant Secretary for Personnel and Labor Relations Ronald E. Cowles testified that it would be very difficult for VA facility directors to use data on compensation paid to CRNAs on a lump-sum basis. CRNAs employed by VA health-care facilities receive both wage and non-wage benefits, such as health insurance. In contrast, CRNAs employed by contractors on a lump-sum-payment basis generally receive higher wages in lieu of non-wage benefits, making it difficult for VA facility directors to utilize data on such compensation to establish fair and competitive salary rates for CRNAs.

To ensure that VA facility directors can effectively utilize data on compensation paid to CRNAs by anesthesia contractors, the Committee modified this authority so as to require VA to survey only compensation paid to CRNAs who are employed on a salary basis. The Committee notes that, pursuant to section 7451(c)(6)(A) of title 38, United States Code, VA facility directors would be required to collect data on both salary rates and other, non-wage, benefits, to the extent such benefits are reasonably quantifiable. Quantifiable benefits may include health and malpractice insurance and retirement annuities.

Use of data on transaction rates

Section 104 would require the director of a VA health-care facility to survey the minimum rates of pay actually paid (transaction rates) to employees in covered positions by non-VA facilities in the local labor-market area. The VA Nurse Pay Act of 1990 requires VA to survey the minimum rates of pay established for corresponding positions.

Many non-VA facilities negotiate salaries for individual employees which are significantly higher than the established minimum rates of pay for their positions. Thus, use of data on transaction rates would improve VA health-care facility directors' ability to establish RN rates of pay that are truly competitive.

VA officials have expressed concern that section 104 of the Committee bill might cause VA to establish salary rates for certain positions that are higher than salaries paid to RNs serving in comparable positions at non-VA health-care facilities. According to VA, this could occur if VA rates were based on what competing hospitals were paying for newly hired RNs with training or experience significantly above the minimum qualifications required by VA for such positions. In testimony presented at the Committee's June 3, 1992, hearing, VA's Chief Medical Director, Dr. Holsinger, stated that use of transaction rates would be particularly problematic for the determination of salaries paid to Chief Nurses, as salaries for RNs serving in comparable positions at non-VA health-care facilities are often determined on an individual basis.

The Committee appreciates these concerns, but notes that the Nurse Pay Act contains adequate safeguards against the setting of inappropriately high salary rates. Section 7541(c)(3)(D) explicitly prohibits the director of a VA health-care facility from adjusting the rate of basic pay for any grade in such a manner that the VA facility becomes the pay leader for comparable positions within the local labor-market area in which the VA facility is located. The Committee expects facility directors to use data on transaction rates in a manner consistent with this provision of the Nurse Pay Act.

Transfers from one VA facility to another at VA's request

Section 105 would authorize the Secretary to increase the rate of basic pay paid to an employee in a covered position who transfers, upon the request of the Secretary, to a comparable position at a VA health-care facility at which the rate for that position is lower than that paid at the VA facility from which the employee transferred. Section 105 also would require VA to include information about the use of this authority in the annual report to Congress on the implementation of the Act.

This provision is designed to provide VA with sufficient flexibility to persuade employees in covered positions to accept transfers from one VA health-care facility to another when that is in the best interest of VA. This flexibility is especially important for chief nurse positions, because VA recruits for chief nurse positions on a nationwide basis and, as part of its promotion process, routinely seeks to transfer chief nurses to progressively more responsible positions at VA health-care facilities throughout the Nation. VA officials have advised the Committee that they have experienced increased difficulty in persuading Chief Nurses to accept transfers since the Nurse Pay Act was implemented. Chief Nurses serving at less complex VA health-care facilities in high-wage local labor-market areas, such as the New York metropolitan area, are increasingly reluctant to accept positions at more complex VA facilities in lower wage areas. The Committee expects VA officials to use this authority in a manner that facilitates their goals regarding the transfer of Chief Nurses and other RNs.

The Committee notes that section 105 explicitly prohibits use of this authority in the case of an RN transferred as a result of disciplinary action. Moreover, the authority applies only to RNs who transfer at the Secretary's request. RNs who transfer upon their

own initiative would remain subject to section 7453(e)(1) of title 38, which generally requires that the salaries of transferring RNs be established in a manner consistent with the practices at the VA health-care facilities to which they transfer.

Section 105 also would require VA to include information about the use of this authority in the annual report to Congress on the implementation of the Act.

Cost

With the exception of section 102, which CBO estimates would cost less than $500,000 in budget authority and outlays in fiscal year 1993 and total costs of less than $6.5 million in budget authority and outlays in fiscal years 1993–1997, CBO advises that it could not determine the cost of the provisions of this title of the Committee Print because CBO could not determine how VA would implement them.

TITLE II—PREVENTIVE HEALTH CARE

The Veterans Preventive Health Act of 1992

Title II of the Committee bill (sections 201 through 205) is substantively identical to S. 2740, the proposed "Veterans Preventive Health Act of 1992." The provisions of this title would revise the definition of preventive health services, repeal a pilot project pursuant to which VA furnished preventive health services to certain veterans, establish a National Center for Preventive Health, establish a VA Advisory Committee for Preventive Health, and require a series of reports within VA and to Congress.

Background

Preventive health efforts have existed for centuries. Indeed, so much of preventive health is second nature now that the public no longer identifies it as such. As a result of separate plumbing lines for sewage and drinking water, the public does not worry about cholera, a scourge of cities in previous centuries. Nor does the public worry about contracting many avoidable infections in hospitals, because health-care professionals now maintain strict sterile procedures. Vaccines developed out of military need now protect service members—and the public at large—from tetanus, typhoid, and yellow fever, which claimed many more lives than combat injuries in some earlier wars. Most clinicians have never seen a case of smallpox; the disease has been eradicated from the planet, except for what is kept in one vial in a lab to be used to make vaccine just in case there is an outbreak.

Although modern science has not conquered all infectious diseases, it does know how to prevent nearly all of them. What researchers have not yet learned are how to ensure that individuals will take the actions necessary to prevent transmission of, or become inoculated against, infectious diseases and how to prevent the chronic diseases that plague many individuals as they grow older, such as heart disease, stroke, and cancer. At this point, information on how to prevent some disease processes associated with aging is lacking. However, nutritional counseling, smoking cessa-

tion programs, and other preventive health services seem to help delay or ameliorate the discomforts of these processes.

Much is known, as well, about prevention of other disease. Oat bran, low-fat dairy products, and broccoli are associated with reduced rates of some cancers. Routine blood pressure and cholesterol screenings, together with medical and personal responses to abnormal results, are associated with reduced rates of cardiovascular disease. Scientists need to learn more about how these associations work. Clinicians also must heed empirical evidence regarding the efficacy of preventive interventions while researchers and the public await explanations as to why they succeed.

In this time of vigorous debate regarding the fate of our nation's health-care system, prevention may be the one thing on which all parties can agree. For example, last year, Senator Lloyd Bentsen and Representative Dan Rostenkowski introduced companion measures, S. 1231 and H.R. 2565, which would extend Medicare coverage for certain additional screening examinations. The House and Senate each passed preventive health care bills, H.R. 3635, introduced by Representative Henry Waxman, and S. 1944, introduced by Senator Edward Kennedy. Many of the 26 health-care reform proposals introduced during the 102nd Congress recommend expansion of preventive health services.

The Committee's consideration of preventive health services in VA dates back to 1976. That year, Senator Cranston first introduced legislation to authorize VA to furnish preventive health services. Three years later, in 1979, provisions introduced by Senator Cranston and reported by the Committee establishing VA's first preventive health services pilot program were enacted in section 105 of Public Law 96–22. That pilot program required VA to furnish preventive health services to veterans with service-connected disabilities rated at 50 percent or greater and veterans receiving VA care for treatment of a service-connected disability. In 1983, provisions enacted in section 106 of Public Law 98–160 extended the preventive health services pilot program through fiscal year 1988. Public Law 98–160 also required VA to furnish each veteran who was receiving VA care to which he or she was entitled (rather than merely eligible to receive) at least one preventive health service per year and authorized VA to furnish preventive services to all veterans receiving VA care.

In implementing Public Law 98–160, VA required each VA health-care facility to designate a Preventive Medicine Coordinator. VA also established the Preventive Medicine Field Advisory Group, a group of VA health-care professionals who serve as a liaison between VA health-care facilities and VA Central Office, advise VA's Chief Medical Director (CMD) regarding preventive health services, and select an annual VA health promotion initiative for implementation VA-wide. Although the legislative requirement for the preventive health services pilot program expired on September 30, 1988, VA has continued to furnish a variety of preventive health services, including annual health promotion initiatives. These annual initiatives, originally implemented in 1985, have included influenza immunizations, colorectal cancer screening, smoking cessation (twice), cholesterol screening, and alcohol misuse inquiry and counseling.

On paper (Veterans Health Administration Clinical Affairs Manual M–2, Part IV, Chapter 9, dated September 11, 1991), VA has a well-planned preventive services program. The areas covered include screening tests (for hypertension, cholesterol, and colorectal, cervical and breast cancer), influenza immunization, and inquiry/counseling (regarding smoking, alcohol abuse, nutrition/weight control, physical fitness/exercise, and seat belt usage). In addition to these basic components—which are accompanied by operational management objectives—VA Central Office also sends recommendations to the field. Unfortunately, according to VA preventive medicine officials in central office, these recommendations, such as the May 1989 Clinical Affairs Letter regarding Cardiovascular Risk Factors Clinics Programs, are not effective systemwide because of lack of funds and priority.

In the Committee's view, VA's current preventive health efforts need to be strengthened. With the exception of the annual preventive initiatives, most preventive interventions are performed in a sporadic and unsystematic manner. Overworked clinicians have little time to counsel patients or explore symptom patterns and, thus, offer only limited preventive services such as rudimentary tests of vital signs and perfunctory dietary advice.

A Preventive Medicine Program office was established in VA in 1985. However, no funds are dedicated specifically to preventive health services nor is there an official in VA Central Office with sole responsibility for implementing VA's preventive health goals. Each VA medical center is required to have a designated Preventive Medicine Coordinator (PMC). However, designation as a PMC does not constitute a full-time position but rather the assumption of additional duties which the individual may or may not have sufficient time to perform.

Committee bill

Title II of the Committee bill encompasses both clinical practice and research. Clinical practice of preventive care is in and of itself a worthy endeavor. However, it benefits only those veterans receiving preventive health services. Clinical research on preventive health services, on the other hand, benefits both current and future VA patients, by enabling VA to determine which preventive health services are most effective. VA preventive health services research would benefit non-veterans as well, as VA research findings are likely to have implications for the furnishing of preventive health services by non-VA providers.

Despite official Administration testimony in opposition to S. 2740, VA officials have demonstrated ongoing support for preventive care. VA's current CMD, Dr. James W. Holsinger, Jr., has maintained preventive health services programs, such as the Preventive Medicine Program's annual preventive initiative, and has advocated the expansion of such services. As Dr. Holsinger stated at his 1990 confirmation hearing, in arguing that future healthcare costs for Vietnam-era veterans in particular could be reduced if VA were to provide them with preventive health services, "[I]f I could deal with them while they are in their current age groups on a preventive basis, I could help to reduce our costs markedly when they hit age 65 and on."

For all the rhetoric advocating preventive health services, there is surprisingly little uncontrovertible medical evidence to support claims about their overall effectiveness, especially with regard to the cost effectiveness of specific interventions. The provisions in the Committee bill would provide an opportunity for VA to use its vast medical and administrative resources and large patient population to ascertain the effectiveness of specific preventive health services. VA operates the Nation's largest health-care system. It thus is well-suited for conducting the sort of large-scale, long-term outcomes research, at multiple facilities where desirable, that is necessary for comprehensive evaluations of preventive measures. In addition, the close affiliation of many VA medical centers with major medical schools supports a cadre of highly esteemed medical researchers, including scholars in the field of preventive health services research.

National Center for Preventive Health

Section 203 of the Committee bill would require the Secretary to establish a National Center for Preventive Health. The Center's director would lead the Center in the acquisition, development, and dissemination of information on VA and non-VA clinical practices and research concerning preventive health. The Center could facilitate cooperative research concerning health outcomes resulting from various preventive services, advise VA health-care personnel regarding the conduct of preventive health services activities and research, and issue annual reports to the CMD and the public. Issues that the Center could address include the long-term relationships among screening activities, treatment, and morbidity and mortality outcomes and the cost effectiveness of specific preventive health services.

The Committee bill would give the Secretary the structure with which to build a leading preventive health research, education, and clinical practice resource center. The legislation would also entrust to the Secretary, the Chief Medical Director, and the Director of the Center the discretion and authority to determine how to achieve the goals set forth in this legislation.

The enactment of legislation establishing a VA National Center for Preventive Health would be a significant contribution to, and make clear the Congress' strong interest in, the improvement and expansion of the promising preventive health services programs currently operated by VA. It would signal to the rest of the health-care community, as well, Congress' firm belief in VA's potential to become a leader in preventive health research. By requiring the dissemination of findings of VA-sponsored research in annual reports to the Congress and to the public, the Committee bill is designed to foster VA's growth as a national health-care resource and promote greater interaction among VA and non-VA clinicians and researchers.

There are many examples of the kinds of research and clinical activities the Center could promote. For example, every man is at risk of prostate cancer. The American Cancer Society estimates that 132,000 men in the United States will be diagnosed with it this year, and a quarter of those will die because of it. Similarly, women in the United States are threatened by breast, ovarian, and

uterine cancers. Further research is needed to determine which screening tests, or combinations of tests, are most effective in facilitating diagnosis of such cancers at early stages and, thus, delay or avoid loss of life from those cancers. Additional questions concern the frequency with which tests should be repeated and the stages in the progression of illnesses at which intervention would be most effective. Now is the time, in the Committee's view, to give VA the tools with which to further the understanding of relationships among screening for disease, education about modifying or eliminating risky behaviors, counseling regarding the management of early symptoms, treatment of early disease manifestations, measures of morbidity such as days lost from work, or days in the hospital, or kinds of medications required, and, finally, mortality rates.

Most importantly, the Center would focus on service-disabled veterans, whose care constitutes VA's primary mission. Treatment options in the immediate post-trauma period are a kind of secondary prevention. For example, research, in which VA was involved, has demonstrated that injections of methylprednisolone within 8 hours of spinal-cord trauma can actually prevent catastrophic neurological damage in some cases.

VA researchers and clinicians are also making great strides in understanding and treating the medical developments of spinal-cord-injured veterans. Certain conditions, such as urinary tract infections and kidney damage, develop in unique ways in this population. The National Center for Preventive Health could facilitate research into early recognition of symptoms or ongoing treatment to postpone further complications.

Also, VA is beginning to gain experience with the challenges faced by aging spinal-cord-injured persons. VA is perhaps the only institution that could coordinate and study the care of large numbers of these individuals. It thus has the extremely important opportunity to explore ways, through clinical research and the training of clinicians, to help make the adjustments to aging-related afflictions more comfortable and less disruptive to the activities and enjoyment of life for spinal-cord-injured persons.

There are some conditions for which science offers no current hope of prevention, such as Alzheimer's Disease. However, preventive health services may have a role in maintaining the highest possible functioning following the onset of the disease. VA's resources—its leadership in geriatric assessment and research and its aging patient population—enable it to study the long-term effects of counseling of patients and family caretakers on the delay of functional decline and subsequent decreased quality of life and increased medical and maintenance costs.

Another area in which the Committee believes the Center could lead VA concerns osteoporosis, a condition that is very prevalent among aging women. The Center's impetus could generate collaboration amount VA researchers in endocrinology and orthopedic rehabilitation, along with the collaborative study of women patients at many VA medical centers. For example, a researcher from the Indianapolis VAMC with a joint appointment at the Indiana University School of Medicine recently published, in a major scientific journal, the results of his study showing how lack of estrogen influences bone loss. Because the Center could enhance communications

among research groups within and outside VA, the results of promising studies such as this can be tested in cooperative studies which could be beneficial to all women at risk of contracting this debilitating and disfiguring condition.

As various studies and recent headings of the Committee have demonstrated, women veterans are not proportionally represented among the veterans whom VA's health-care system serves. Partly because of the urging of this Committee and partly because of the growing participation of women in today's military, it is expected that this will change. VA must be ready with appropriate clinical services and research projects to meet the needs and concerns of the increasing numbers of women veterans.

Preventive Health Services Advisory Committee

Section 204 of the Committee bill would establish a preventive Health Services Advisory Committee to assist the Secretary and the Chief Medical Director.

VA benefits from several advisory committees that help it deal with diverse issues, including numerous technical problems and ethical dilemmas. Over the years VA officials have relied upon many of the recommendations made by these advisory committees to enhance the range and quality of health services furnished by VA health-care professionals. The Geriatric and Gerontology Advisory Committee, the Advisory Committee on Women Veterans, and the Special Committee on Post-Traumatic Stress Disorder, for example, have served to further VA and Congressional goals in the areas on which they focus.

The Preventive Health Services Advisory Committee would include clinicians and researchers, health services researchers, as well as representatives of veterans who are furnished health-care services in VA facilities. It could serve as a conduit for information concerning the theory and practice of preventive health services in non-VA institutions. Furthermore, the Secretary could turn to the Advisory Committee for guidance and advice on matters or in situations where the ethical decisions are not clearly evident.

Education of clinicians

The Committee emphasizes that the concepts and practices of preventive health services should be integrated into the education of health professionals. According to the Association of American Medical Colleges, half of all physicians practicing in the United States received at least some of their training in a VA medical center. VA also trains nurses, physical therapist, psychologists, chaplains, podiatrists, optometrists, and others. By emphasizing the concepts and practice of preventive health services in its training programs, VA can enhance the quality of care furnished to veterans served by these clinicians and the patients—both veterans and non-veterans—these clinicians will serve in the future.

The nation's health-care professionals need not only to learn how to perfect surgical interventions but also about how to design successful behavioral interventions that may obviate the need for surgery. Thus, while VA trains the subspecialist who will perform cardiac catheterizations, it also has the opportunity to train the internist or health educator who will try to influence behavior regard-

ing smoking and diet. The Committee believes that VA has the opportunity to take a leadership role in this effort.

Reports

Sections 203, 204 and 205 of the Committee bill would require three annual reports. First, the National Center for Preventive Health would produce an annual report on the Center's and other VA activities regarding research, clinical care, and health professionals' education regarding preventive health. Second, the Advisory Committee would produce an annual report on its activities for the Secretary which the Secretary would submit to the Committees on Veterans' Affairs. Third, the Secretary would furnish a comprehensive report to the Committees on Veterans' Affairs on VA's efforts in this critical field. It is the Committee's intent that such reports serve to inform interested researchers, clinicians, educators, and patients and to encourage further steps in developing and disseminating knowledge that can be used to prevent disease, disability, and discomfort.

Cost

According to CBO, the enactment of title II of the Committee bill would entail costs of $3 million in budget authority and $2 million in outlays in fiscal year 1993 and total costs of $15 million in budget authority and $13 million in outlays in fiscal years 1993–1997.

TITLE III—STATE HOME FACILITIES

Section 301 of the Committee bill is derived from S. 2372; sections 302 through 304 were added as an amendment during the June 24, 1992, markup of S. 2575; section 305 was added as an amendment during the August 7, 1992, markup. These provisions would eliminate a disincentive for recipients of VA needs-based pensions to participate in therapeutic work programs at State Veterans Home facilities, extend the period of time during which a State can meet participation requirements, make available for other State home projects funds for a project that the State is not yet ready to undertake, clarify the "recapture" period, and allow retroactive per diem payments for care provided between a successful inspection and official recognition notification.

Background

Under the State Home Program, VA provides grants to States for the construction, expansion, or remodeling of State-operated facilities furnishing long-term care to veterans (sections 8131 through 8137 of title 38) and makes per diem payments to cover a portion of the cost of care provided to veterans (sections 1741 through 1743 of title 38).

Under current law and regulations, VA awards grants to States based on the priority ranking (as of August 15) of approved applications for a fiscal year. Under section 8135(c)(6), the Secretary has the authority conditionally to approve a project where the Secretary determines that it will meet all the approval criteria within 90 days after the approval. Approximately 25 percent of approvals are

such conditional approvals. If a project does not meet all the criteria within 90 days, the funds are deobligated.

If VA provides funding to construct or renovate a facility to be used by a State as a State veterans home and, within 20 years after completion, the State ceases to so operate the facility, VA can recover 65 percent of the current value of the facility.

Committee bill

Treatment of compensation of veterans under certain rehabilitative services programs

Section 301 of the Committee bill would amend section 1718 of title 38 to add a new subsection (g) that would (a) clarify that neither a veteran's participation in a State home incentive therapy (IT) or compensated work therapy (CWT) program that the Secretary approves as conforming to VA standards, nor a veteran's receipt of payment for participating in such a program, may be used as a basis for denying or discontinuing a rating of total disability on the basis of unemployability; and (b) provide that a payment to a veteran participating in an approved State home IT or CWT program shall be considered to be a donation from a public or private relief organization.

Under current law, veterans in receipt of need-based pensions are allowed to participate in IT or CWT programs administered by VA without any effect on the amount of their needs-based VA pensions. However, the income received by veterans participating in IT or CWT programs administered by a State veterans home is counted as income for VA pension purposes and thus reduces, on a dollar-for-dollar basis, the amount of pension those veterans receive. Section 301 would simply extend to veterans who earn wages through VA-approved IT or CWT programs in State homes the same exemption from countable income that was granted to veterans participating in similar VA programs.

Section 1718 of title 38 authorizes VA to operate therapeutic and rehabilitation programs under which VA patients—either inpatients, residents in domiciliary facilities, or outpatients—perform services for which they receive a small payment. Many State veterans homes run substantively similar IT and CWT programs. IT and CWT programs encourage the development of good work habits by emphasizing attendance, reliability, punctuality, productivity, craftsmanship, and personal responsibility. Individuals working in these programs gain a sense of being productive while developing important work skills and thus become less dependent on long-term hospitalization and other support from Federal, State, and local government sources.

An August 27, 1985, report of the Comptroller General entitled "Impact of Offsetting Earnings from VA's Work Therapy Programs from Veterans' Pensions," found that the pension offset then in effect with respect to VA's own IT and CWT programs had detrimental effects on veterans participating in the programs and on the work therapy programs themselves. Additional information provided to the Committee at that time indicated that counting the remuneration as income for pension purposes was acting as a significant disincentive to veterans' participation in these two pro-

grams and, as a consequence, was adversely affecting their rehabilitation.

To remedy the situation, the Committee reported legislation that the Senate passed on October 21, 1984, as part of H.R. 5688, but was not included in the compromise legislation that was enacted that year. In 1985, the same provision was reintroduced and the Senate passed it as part of S. 1887 in December 1985. In October 1986, Congress enacted, in section 205 of Public Law 99–576, a provision that amended section 618 (now section 1718) of title 38 to provide that remuneration received by veterans under these VA programs would be considered as donations from public and private relief organizations, which, under section 1503(a)(1) of title 38, are not considered as income purposes of VA pension programs.

VA officials in San Francisco had originally interpreted the 1986 legislation as exempting State home IT and CWT participants' income for purposes of calculating VA pension. However, the Committee learned this year that in July 1991 IT and CWT participants in the California State Veterans Home at Yountville had begun receiving notifications from VA that they owed VA refunds of overpayments of pension based on the exclusion of their IT and CWT payments from the calculations of their incomes for VA pension purposes. The San Francisco VA Regional Office subsequently requested an advisory opinion regarding the interpretation of section 1718(f) from the Compensation and Pension Service (CPS) in VA Central Office. The CPS opinion, dated October 24, 1991, concluded that veterans in State homes are not covered by the exemption in section 1718(f) of title 38.

The Committee has learned that the reduction in pension for veterans participating in the California State home IT and CWT programs is adversely affecting the intent of the therapeutic programs by making veterans pay for participating in rehabilitative, therapeutic work activities. According to a January 6, 1992, survey by the National Association of State Veterans Homes (NASVH), 23 State homes operate therapeutic work programs and thus are in a similar situation to that of the Yountville State home.

In written testimony submitted to the Committee for the June 3, 1992, hearing on S. 2372 (from which section 301 of the Committee bill was derived), Jack J. Dack, Chairman of the NASVH Legislative Committee, declared his organization's strong support for S. 2372 and stated that, "NASVH views [counting pay received by IT and CWT patients in State veterans homes as income for pension purposes] as a deterrent to veterans becoming or staying involved in Incentive Therapy Programs in State Veterans Homes."

Admiral B.T. Hacker, Director, California Department of Veterans Affairs, stated in written testimony submitted for the June 3 hearing, "It is not likely that the affected members [participating in the California State home IT and CWT programs] will continue employment in the program when their pensions will be offset by each dollar they receive from the Therapeutic Work Incentive Program."

The Committee notes that the provisions of section 301 parallel as closely as possible the provisions under current law that protect VA programs. In order to ensure that the covered State veterans home IT and CWT programs are consistent with the VA program

model set forth in section 1718 of title 38, the Committee bill would require, as a prerequisite to exemptions from countable incomes for participants in a State home program, that the Secretary of Veterans Affairs approve the State home's program of rehabilitative services pursuant to the standards set forth under section 1718.

Technical amendments

The National Association of State Veterans Homes (NASVH) approached the Committee last year for four concerns regarding VA's administration of the State Home Program. Specifically, NASVH requested four legislative proposals: (1) to extend from 90 days to 180 days after receiving conditional approval the period during which a State can meet all requirements for a grant, (2) to allow VA to use funds deobligated for use for a particular project because it was not ready for construction towards other high-priority but not funded projects during a fiscal year, (3) to define specifically the start of the recapture period, and (4) to allow VA to make retroactive per diem payments to States for the care provided to veterans in State veterans homes for the period between the recognition inspection and the notification of recognition. Initially, it appeared that legislation was not necessary to address the first, third, or fourth these concerns. However, after further consultations with VA officials, it appears that legislation would be the most desirable means for addressing all four of these concerns in a timely manner.

Sections 302 through 305 are technical amendments to section 8135 of title 38.

Under current law, a State has 90 days after conditional approval of a project to meet all requirements for the award of a grant. When a State is unable to meet the deadline, funds for that project are deobligated, yet are not available for VA to use for other approvable projects that are ready for construction. Two changes proposed in the Committee bill world make the granting procedure more realistic. First, changing the 90-day period to one of 180 days would give a State a better opportunity to complete Federal requirements, advertise for bid, select a contractor, and submit the final paperwork to VA. Second, giving VA the authority to use the deobligated funds for other States whose applications ranked high enough on the priority list to receive funds for that fiscal year would help VA make more effective use of appropriated funds on a timely basis.

Section 302 would extend from 90 days to 180 days the period, following approval of a State's application for State Home Program funds, within which a State must meet all requirements for participation in the State Home Program. According to both NASVH and VA, the 90-day conditional approval period in current law does not provide many States with sufficient time to satisfy the requirements.

Section 303 would prohibit the obligation of funds for a State's project until the beginning of the next fiscal year if a State fails to complete all requirements for participation in the State Home Program within the conditional-approval period. This provision would ensure that, if a State fails to complete all requirements within the conditional-approval period, funds originally earmarked for the

State's project could be used to fund projects in other States for which the requirements have been met.

Section 8136 of title 38 specifies a 20-year recapture period, during which VA is entitled to recover 65 percent of the value of a facility for which State Home Program funds were provided if the State has ceased to operate it as a State veterans home. Neither current law nor regulations specify the event that officially starts the recapture period.

Section 304 would specify that the "recapture" period begins on the date on which the final architectural and engineering inspection is completed for a facility funded through the State Home Program.

Current regulations (38 CFR 17.165c) require that a State veterans home be officially recognized as such by the Secretary before any payment of per diem can be made to the State for care provided by the home. Official recognition may not occur for up to three months after a final VA inspection of the facility (known as a "recognition inspection") has been completed because the results of that inspection must be reviewed by VA officials in Washington, DC. During this three-month period, the States often admit patients but cannot receive per diem retroactively to the date of the inspection.

Section 305 would authorize the Secretary to provide retroactive per diem payments to a State for care to veterans in a State Home in the period between the recognition inspection and the official notification of recognition.

Cost

According to CBO, the enactment of section 301 of the Committee bill would entail costs of $1 million in both Budget Authority and outlays in fiscal year 1993 and total costs of $5 million in both Budget Authority and outlays in fiscal years 1993–1997; the enactment of sections 302 through 305 would entail negligible costs.

TITLE IV—RURAL HEALTH-CARE CLINICS

Background

The Committee has long been interested in and concerned about access to VA health-care services for veterans in rural areas. In July 1983 and again in November 1989 the Committee held hearings on this issue. At both hearings the Committee heard testimony about problems affecting veterans living in rural areas, including problems associated with travel distances, adverse weather conditions, and the capacity of health-care facilities to meet veterans' needs. Similar concerns were raised at a field hearing the Committee held on July 1, 1991, in Charleston, West Virginia, on West Virginia veterans' access to VA health-care services.

According to VA's February 1986 report, "Study of Health Care Services to Veterans Living in Geographically Remote Areas," veterans living in rural areas are proportionately higher users of VA health-care services than veterans in urban areas. The study also found that there is a higher percentage of persons living below the poverty level in rural areas as compared to highly urbanized areas; that the further away veterans live from a VA facility, the less

likely they are to seek VA care, particularly outpatient care; and that there are slightly more service-connected-disabled veterans per 1,000 population in the lesser populated areas.

One significant difference between urban and rural veterans is the greater obstacles they face in traveling to VA health-care facilities. For example, in North Dakota over 34,000 veterans—more than 50 percent of the State's total veteran population—live in counties 100 miles or more from the only VA health-care facility located in that State. The situation is even more severe in eastern Montana, where 83 percent of veterans live more than 100 miles from the nearest VA facility. In contrast, the Chicago metropolitan area has four VA medical centers, several of which are located on major public transportation routes.

Difficulties in traveling to VA health-care services are not confined to veterans living 100 miles or more from the nearest VA health-care facility. Although most West Virginia veterans live within 100 miles of one of that State's four VA health-care facilities, rugged topography, poor roads, and sporadic public transportation combine to make it difficult for many veterans to reach those facilities. Veterans living in other mountainous States encounter similar difficulties.

For many years the Committee has urged VA to explore various alternatives for improving access to VA health-care services for veterans living in rural areas and has supported the development of various pilot programs to identify effective means for achieving that goal. In September 1986, the Senate Committee on Appropriations directed VA to establish a pilot program to test two different means for expanding VA health-care services in rural areas (S. Rept. No. 99–487, p. 87). In response to that directive, VA established two satellite, community-based clinics—one, in Redding, California, operated by VA personnel, and the other, in Farmington, New Mexico, operated by a non-profit organization under contract with VA. According to an evaluation completed by the Palo Alto, California, VA Medical Center's Far West Health Service Field Program in 1991, both clinics have expanded access to VA ambulatory health-care services for veterans living in geographically remote areas and provided such services at costs comparable to those incurred at other VA facilities.

The Committee also supported section 113 of Public Law 100–322, enacted on May 20, 1988, which required VA to implement a two-year pilot program of mobile health-care clinics, provided that funds were appropriated specifically for that purpose. Under that program, VA was to establish geographically-dispersed projects using appropriately equipped mobile vans to furnish health-care services to veterans in rural areas at least 100 miles from the nearest VA health-care facility. In addition, VA was required to submit to the House and Senate Veterans' Affairs Committees reports on VA's experience during the program and, at its conclusion, reports containing information and detailed breakdowns on services provided, costs, and client characteristics, as well as an evaluation of the program.

Unfortunately, no funds were appropriated for this program for fiscal year 1989. For fiscal year 1990, however, $3 million was appropriated in the Departments of Veterans Affairs and Housing

and Urban Development and Independent Agencies Appropriations Act, 1990, (Public Law 101–144) for the rural mobile health clinics one of which was to be located in Arizona. Although there was no specific appropriation for mobile clinics in fiscal year 1991, VA moved forward with the program, awarding a contract for the manufacture of the mobile clinic vehicles and selecting five sites: Fayetteville/Durham, North Carolina; Poplar Bluff, Missouri; Prescott, Arizona; Spokane, Washington; and Togus, Maine. In fiscal year 1992, funds were appropriated for establishment of an additional mobile clinic to be located in Vermont. VA officials expect to begin operating three of the clinics by mid-September 1992 and the other three by early October 1992.

Committee bill

The rural health-care clinic provisions of the Committee bill are designed to further the Committee's goals with regard to the exploration of various alternatives for improving access to VA health-care services for veterans living in areas geographically remote from VA health-care facilities. Under the rural health-care program, VA would be required to establish and evaluate three means for furnishing health-care services to these veterans: (1) mobile health-care clinics equipped, operated, and maintained by VA personnel, (2) part-time stationary clinics operated by VA personnel, and (3) part-time stationary clinics operated through contracts with non-VA entities. Utilization and evaluation of three different means for furnishing ambulatory care services should enable VA to determine the geographic conditions and ranges of services for which mobile clinics or part-time stationary clinics are more effective.

In determining what health-care services will be provided through rural health-care clinics, the Committee expects VA to draw upon the experiences of VA health-care facilities and non-VA facilities which currently operate mobile clinics and part-time stationary clinics. For example, one model for furnishing health-care services through a mobile clinic of which the Committee is aware is the Checkup and Routine Examinations (CARE) Van operated by the Lebanon, Pennsylvania, VA Medical Center. The CARE Van augments the Lebanon VAMC's services by providing preventive screening examinations to veterans living in isolated farming and mountain communities in central Pennsylvania. The CARE Van's staff is composed of a physician's assistant, a licensed practical nurse, and a medical administration service clerk. This staff performs physical examinations, administers preventive screening tests, counsels veterans on reduction or cessation of smoking and other unhealthy behaviors, and refers veterans requiring follow-up treatment to the Lebanon VAMC or its satellite outpatient clinic in Harrisburg or, if the veteran chooses, to a private physician.

The Committee notes that mobile clinic programs need not be limited to preventive screening. For example, Valley Health Systems, Inc., of Huntington, West Virginia, under a grant awarded by the Children's Health Fund, operates a mobile clinic in isolated areas of four West Virginia counties that provides both preventive screening and routine primary outpatient care. The mobile clinic is currently operated two days per week and is staffed by a pediatri-

cian, a pediatric or family practice resident, a pediatric nurse practitioner, a clerk, and a driver. According to a Valley Health Systems administrator, since January 1992, approximately 500 episodes of care involving comprehensive physical examinations, vaccinations, and other routine primary care services have been furnished to approximately 200 children, many of whom would not otherwise have had access to such care. Children requiring services not furnished through the mobile clinic are referred to primary-care facilities operated by Valley Health Systems or pediatric specialists affiliated with Marshall University.

The strength of the mobile clinic approach is its flexibility. Such clinics can treat small, scattered veteran populations in remote areas where the workload is insufficient to justify establishment of a permanent clinic. They can be shifted among various locations to accommodate fluctuating demand and to provide veterans with convenient access to care.

However, the Committee recognizes that mobile clinics may not constitute the most effective means for furnishing health-care services to veterans—at least not in all rural areas. Several VA medical centers which operated mobile clinics during the 1980s discontinued those programs due to difficulties regarding vehicle maintenance and recruitment and retention of staff. Thus, the Committee bill requires VA to establish both mobile and part-time stationary clinics and to evaluate both types of clinics.

Like mobile clinics, part-time stationary clinics can furnish various services depending on the needs of veterans living in particular remote areas. Several VA medical centers already operate programs comparable to the part-time stationary clinics envisioned by the Committee. The Salt Lake City, Utah, VA Medical Center operates a program through which physicians employed by the Salt Lake City VAMC fly to VA medical centers in Grand Junction, Colorado, and in Fort Harrison and Miles City, Montana, several days each month to furnish specialized diagnostic and treatment services that would otherwise be unavailable at those facilities. According to the Chief of Staff of the Salt Lake City VAMC, this program has proven to be very cost-effective because the cost of chartering an airplane to fly a group of specialist physicians to the three VA medical centers is considerably lower than the cost of transporting individual veterans from those locations to Salt Lake City. Transportation and referral to the Salt Lake City VAMC is generally limited to those veterans whom specialists determine require sophisticated surgical procedures and other services that the other VA medical centers lack the resources to provide.

Other VA medical centers have established part-time stationary clinics through which health-care services are furnished by non-VA health-care professionals. One of the most successful programs of this type is the Farmington, New Mexico, VA Community Clinic noted above. A joint venture between the Albuquerque VA Medical Center and Presbyterian Medical Service, the clinic furnishes a full range of ambulatory care services, including pharmacy, laboratory, and radiology services. Health services are provided by employees of Presbyterian Medical Services who refer veterans who require services not furnished by the clinic to the Albuquerque VAMC.

A less comprehensive, yet no less significant, part-time stationary clinic was recently established by the San Francisco VA Medical Center. Beginning in January 1992, the medical center entered into a contract with a private physician to furnish preventive screening examinations three days per week in his office in Eureka, California, a small city approximately 275 miles north of San Francisco on the California coast. Referrals for follow-up care are facilitated by a program analyst employed by the San Francisco VAMC who travels to Eureka to work with the physician on days on which screening examinations are conducted. San Francisco VAMC officials have located a physician in Ukiah, another isolated Northern California community, who is willing to enter into a similar arrangement to furnish preventive screening to veterans living in that area.

Unlike the mobile clinic pilot program established under Public Law 100–322, the rural health-care clinic program would not restrict access to veterans living at least 100 miles from the nearest VA health-care facility. Instead, the Committee bill would authorize the Secretary to establish rural health-care clinics in areas less than 100 miles from the nearest VA health-care facility if the Secretary determines those places to be appropriate for furnishing such services. In many States significant numbers of veterans living in areas that are less than 100 miles from the nearest VA facility lack ready access to VA facilities because of poor roads or inadequate public transportation services. In inclement weather, a fifty-mile trip along a winding mountain road may be more time-consuming than a 100-mile trip across flat terrain.

To ensure that care from rural health-care clinics is available to veterans on a geographically-distributed basis, the Committee bill would prohibit VA from establishing more than one clinic under this program in any one State. The Committee further recommends that VA establish at least two clinics in each of the four regions into which the Veterans Health Administration is organized. The Committee bill would require that at least three of the nine clinics established under the rural health-care clinic program be mobile clinics. With regard to the other six clinics, the Secretary would have the discretion to determine what combination of mobile and part-time stationary clinics would be most appropriate to carry out the program's goals.

The Committee bill also mandates that VA carry out an evaluation of the rural health-care clinic program. The Secretary would be required to submit to Congress a report on the program which would contain information regarding the types of health-care services furnished under the program, including a detailed specification of the cost of such services, the veterans furnished services under the program, and the types of personnel who furnished services to veterans under the program. With regard to the veterans furnished services under the program, the report would be required to contain an analysis of the extent to which these veterans otherwise would have received VA health-care services and the types of services they would have received.

In recognition of the fact that VA's health-care programs face tight budget constraints, the Committee bill prohibits VA from ex-

pending funds for the rural health-care clinic program unless expressly appropriated for that purpose.

Cost

According to CBO, the enactment of title IV would entail costs of $3 million in budget authority and outlays in fiscal year 1993 and total estimated costs of $18 million in budget authority and outlays in fiscal years 1993–1997.

TITLE V—TELEPHONE USE DEMONSTRATION PROJECT

Title V of the Committee bill, which is derived from S. 2715, would require VA to establish demonstration projects at the VA Medical Centers in Philadelphia, Pennsylvania, and Tucson, Arizona, to evaluate cost, benefit, and technical considerations raised by the long-term objective of installing telephones in patient rooms throughout VA's health-care system.

Background

As a general rule, VA's 171 medical centers—which comprise the nation's largest health-care delivery system—do not offer bedside telephone service to their patients. Rather, VA patients usually make outgoing calls at pay phones in hospital corridors or, in some VA medical centers, with portable telephones mounted on carts which are wheeled to the patients' rooms by nursing staff. Incoming calls to VA patients generally must be made to corridor pay telephones in the hope that someone will "pick up" or, in some cases, may be routed to an nursing station in the patient's ward, where staff may have the technical capability of delivering a telephone to the veteran-patient so that he or she may receive the call. In the absence of such technical capability, nursing staff must deliver "call back" messages to patients, some of whom are bedridden and, therefore, cannot return calls.

In such cases, it is difficult, if not impossible, for veteran-patients to make and receive telephone calls, and to maintain beneficial, therapeutic communication with family, loved ones, and friends. Where nursing staff is able to facilitate patient communication through the referral of calls through nursing stations or via portable phones, staff is able to do so only by diverting a significant portion of its time and attention from clinical tasks. In connection with the issue of the diversion of nursing staff time and attention, a General Accounting Office report has concluded as follows:

> Assisting patients with telephone calls is one of the primary nonclinical tasks that adversely affect nurse productivity. An analysis of nursing activities at the Boise, Idaho, VA medical center estimated that before bedside telephones were installed (financed with a gift from the estate of a deceased veteran), nursing staff in the medical and surgical wards were spending 2,600 hours a year providing telephone-related services for patients. Further, nurses we interviewed at three VA medical centers in San Diego, California; Columbia, Missouri; and Washington, D.C., reported that helping patients with telephone calls is a time-consuming activity that reduces the time available to pro-

vide direct nursing care. For example, nurses at the Columbia medical center are required to locate a pay telephone on a cart and wheel it to the room of any bedridden patient who wants to make or receive a call.

VA health care: Telephone service should be more accessible to patients, B–244899, July 31, 1991.

The Committee is not critical of the attempts of nursing staff to assist veteran-patients in making and receiving calls. At a time, however, when costly nursing resources are in short supply, the productivity and morale of each medical center's professional nursing staff must be maximized. The Secretary of Veterans Affairs would appear to have confirmed this assessment in an August 10, 1992 letter to the Committee's Ranking Republican Member, in which he stated that "there is general agreement that providing bedside telephone access will result in a more effective utilization of nursing resources. * * *" (The Secretary's letter is printed at the end of this part of the discussion of title V of the Committee bill.)

However, with respect to the issue of benefits to be gained from bedside telephone installations, the Committee's main focus is not on the effective utilization of nursing staff, as crucial as that issue is, but rather on the benefits to the patient of ready access to telephone service. The Committee believes that therapeutic benefit will be derived from ready and private access to communication with family, other loved ones, and friends. The Committee also believes that communications with work associates and with community businesses and support resources may result in therapeutic benefit by reducing patient anxiety and isolation, and by maintaining and enhancing ties to the community. The Secretary of Veterans Affairs noted in his letter of August 10, 1992, to the Committee's Ranking Republican Member that VA's Veterans Health Administration had "confirmed that patient telephones are therapeutic in most medical center settings."

The Secretary's letter is printed below:

THE SECRETARY OF VETERANS AFFAIRS,
Washington, DC, August 10, 1992.

Hon. ARLEN SPECTER,
Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate, Washington, DC,

DEAR SENATOR SPECTER: I appreciate this opportunity to clarify the Department of Veterans Affairs' (VA) position on providing patient bedside telephone access in general and specifically at the Philadelphia and Tucson VA Medical Centers (VAMCs). There is general agreement that providing bedside telephone access will result in more effective utilization of nursing resources, and is desirable from the patient standpoint. Recently, the Associate Deputy Chief Medical Director for Clinical Programs in the Veterans Health Administration confirmed that patient telephones are therapeutic in most medical center settings.

The demonstration projects proposed for the Philadelphia and Tucson VAMCs will be used to gather information and make informed decisions on nationwide implementation of patient tele-

phones. To facilitate this process, the Department is building the requirement for patient telephones in the FY 92 solicitation for a telephone replacement system at the Tucson VAMC. With respect to the Philadelphia VAMC, a meeting with Bell Atlantic was held on June 24, 1992, in Philadelphia to discuss potential interim solutions for the installation of patient telephones. As a result of this meeting, Bell Atlantic representatives have agreed to perform a technical analysis and present their findings and recommendations to VA in the near future.

We will keep you apprised of our plans for the Philadelphia and Tucson VAMCs. Please contact me if you need additional information about the demonstration projects or other aspects of health care information systems in VA.

Sincerely yours,

EDWARD DERWINSKI.

Committee bill

Title V of the Committee bill would direct VA to install bedside telephones in two VA medical centers and, based on the experience gained through those installations, evaluate the costs, technical problems and alternative solutions—whether the telephone system should be "hard-wired"; whether cellular technology is feasible in hospital settings, particularly setting where the extensive presence of modern diagnostic and treatment equipment requires shielding; whether the telephone system should also be designed to accommodate the transmission of data; and, finally, the benefits, from the standpoint of both patient and staff, of the furnishing of bedside telephone service.

The Committee notes that many of VA's health-care facilities were built at a time when there was no expectation that bedside telephone installations would become the norm. Accordingly, it is anticipated that the retrofitting of older VA facilities would be necessary to accommodate modern communication needs. The Committee anticipates that VA's report to the Congress, which would be furnished by VA not later than September 30, 1994, would address, in detail, the issue of retrofitting costs.

The Committee acknowledges, and is encouraged by, the statement made by VA's Deputy Secretary at the June 24, 1992, Committee meeting that VA now intends to calculate the costs of a program of system-wide telephone installations for presentation to the Congress in its proposed fiscal year 1994 budget. It is equally encouraged by the statement of the Secretary in a August 10, 1992, letter to the Committee's Ranking Republican Member that "the demonstration projects proposed for the Philadelphia and Tucson VAMCs will be used to gather information and make informed decisions on nationwide implementation of patient telephones." The Committee intends that the Philadelphia and Tucson demonstration projects would lead the way to national installations.

Cost

According to CBO, enactment of title V of the Committee bill would entail costs of $2 million in budget authority and outlays in fiscal year 1993 and negligible costs in fiscal years 1994–1997.

TITLE VI—PROCUREMENT OF PHARMACEUTICALS

Title VI of the Committee bill, which was added by an amendment offered at the Committee's meeting on August 7, 1992, by Senators Rockefeller, Simpson, Murkowski, and Cranston to S. 2575 (as ordered reported by the Committee on June 24, 1992), would (1) require manufacturers of drugs and biologicals to enter into master agreements with the Administrator of the General Services Administration under which the manufacturers who wish to sell their products to any federal entity or any entity receiving Public Health Service (PHS) funds or to receive Medicaid reimbursement agree to participate in the Medicaid outpatient prescription drug rebate program and to sell drugs and biologicals through the Federal Supply Schedule (FSS), Department of Veterans Affairs (VA) depots, and Department of Defense (DoD) depots at prices determined under minimum percentage discount mechanisms established in this legislation; (2) establish mechanisms that would limit increases in FSS, VA depot, and DoD depot prices to rates no greater than increases in the Producer Price Index-Finished Goods; (3) permit State Veterans Homes to purchase drugs and biologicals listed on the FSS at prices no greater than FSS prices; and (4) authorize VA to negotiate unified pharmaceutical award contracts for use by other Federal, State and local government programs, as well as VA itself.

Background

Impact of Medicaid's best-price rebate mechanism on VA's costs

On November 5, 1990, legislation enacted in section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) established the Medicaid outpatient prescription rebate program. That legislation, derived from S. 3029 of the 101st Congress, introduced by Senator David Pryor, and H.R. 5589 of the 101st Congress, introduced by Representatives Ron Wyden and Jim Cooper, requires pharmaceutical manufacturers to provide to State Medicaid programs rebates on reimbursement for drugs and biologicals dispensed to Medicaid beneficiaries on an outpatient basis equal to the larger of (1) a fixed percentage discount from the average manufacturer price, or (2) the difference between the average manufacturer price for each of their products and the "best-prices" charged to any other purchaser. As Senator Pryor noted in his introductory statement on S. 3029, the purpose of the legislation was to reduce the approximately $5 billion in annual State and federal expenditures for Medicaid outpatient prescription drugs. 136 Cong. Rec. S12954 (daily ed. Sept. 12, 1990). The Congressional Budget Office estimates that the rebate program yielded $176 million in savings in federal Medicaid costs during fiscal year 1991 and will yield $705 million in such savings during fiscal year 1992.

Unfortunately, the establishment of the Medicaid rebate program also resulted in unintended, adverse consequences for the Department of Veterans Affairs' health-care program as well as other federal health-care programs. Since the enactment of OBRA 90, FSS prices have increased dramatically. These price increases are

due, at least in part, to some manufacturers' efforts to avoid having to provide State Medicaid programs—through the best-price mechanism—prices as low as pre-OBRA 90 FSS prices. In addition, prices for many drugs and biologicals purchased through VA depots also have increased significantly, even though these depot prices are exempt from Medicaid best-price rebate calculations.

Prior to the enactment of OBRA 90, prices charged to the federal government for many drugs and biologicals purchased through the FSS were among the lowest prices charged to any purchasers in the United States. Two major factors appear to have accounted for manufacturers' pricing practices. First, manufacturers wanted physicians in training to become familiar with their products. According to the Association of American Medical Colleges, each year more than 30,000 medical residents and 22,000 medical students receive a portion of their training in a VA health-care facility. Because physicians' prescribing habits are shaped during their training, manufacturers had an incentive to negotiate significant discounts for FSS prices in order to ensure that VA facilities stocked their products. Second, because FSS sales constitute a small percentage of the total U.S. market—approximately 1.5 percent—many manufacturers negotiated deep discounts for FSS prices in anticipation of the generation of greater sales by physicians who prescribed their products during training. This practice has been a particularly effective tool for marketing brand name drugs for which therapeutic and generic equivalents are available. However, since the enactment of OBRA 90, many manufacturers have ceased this practice because they do not want to provide Medicaid—which accounts for approximately 13 percent of the U.S. market for pharmaceuticals—with prices as low as pre-OBRA 90 FSS prices.

VA uses several mechanisms for purchasing drugs and biologicals. The most widely used is the FSS, a published list of drugs and biologicals available at prices negotiated with manufacturers by VA under authority delegated to VA by the General Services Administration. According to VA officials, FSS purchases account for approximately 50 percent of VA's expenditures for drugs and biologicals. Health-care facilities operated by the Department of Defense, the Bureau of Prisons, and the Public Health Service, including Indian Health Service facilities, have authority to purchase drugs and biologicals through FSS and regularly do so, because FSS prices historically have been much lower than open market prices for most drugs and biologicals.

A second mechanism VA uses is its depot system, which accounts for approximately 25 percent of VA's total expenditures for drugs and biologicals. As part of this system, VA operates three large warehouses at which drugs and biologicals and other medical items are stored for distribution to VA health-care facilities. VA uses depots primarily for products that have a long shelf-life and are widely utilized by VA health-care facilities. Depot prices for most drugs and biologicals historically have been even lower than FSS prices, because VA, rather than the manufacturer, bears the cost of distributing a drug or biological through the depot system. DoD and PHS also operate depots through which they purchase and store drugs and biologicals at prices comparable to those charged to VA for drugs and biologicals distributed through VA depots.

The remaining 25 percent of VA's purchases of drugs and biologicals are made in a variety of ways, including single-award contracts, direct vendor contracts, and open-market purchases. Under a single-award contract, VA contracts with a manufacturer for the manufacturer to be VA's sole supplier of a widely-utilized drug or biological. By soliciting competitive bids from manufacturers, VA has been able to negotiate deep discounts on the prices it pays for intravenous solution and certain other pharmaceuticals.

In addition, VA purchases some drugs and biologicals at open market prices. Such prices are usually much higher than FSS, depot, single-award, or prime vendor contract prices. VA facilities generally buy at open market prices only in emergency circumstances or when a manufacturer refuses to sell a drug or biological in any other manner.

VA officials estimate that prices for all drugs and biologicals listed on the FSS in both fiscal year 1990 and fiscal year 1991 increased an average of 14 percent during fiscal year 1991. These increases in prices for pharmaceuticals far exceeded the average annual rate of increase in FSS and depot prices—approximately 4 percent—during the two years prior to the enactment of OBRA 90. FSS prices for some drugs and biologicals escalated even more dramatically. According to VA officials, the FSS price for a package of ten 1-milliliter vials of Ativan (NDC #000008058102) increased approximately 83 percent, from $45.78 to $83.69. The FSS price for a 1,000-tablet package of 100-milligram capsules of Dilantin (NDC #000071036232), a drug used to control epileptic seizures for which no generic equivalents are available, increased from $35.89 in September 1990 to $102.30 in April 1992—an increase of approximately 185 percent. In contrast, the average wholesale price and the average price charged to retail pharmacies increased only 25 percent from December 1990 to December 1991, according to a recent U.S. General Accounting Office report, "Prescription Drugs: Changes in Prices for Selected Drugs," (GAO/HRD–92–128, August 24, 1992). Other, similar examples may be found in GAO's report.

Costs for many other drugs and biologicals have risen because manufacturers refused to continue selling them through FSS. If drugs and biologicals are neither available through the FSS nor stocked in federal depots, VA, DoD, and PHS have little choice but to purchase many of them at open market prices. VA officials estimate that its prices for drugs and biologicals deleted from FSS contracts during fiscal year 1991 increased an average of 80 percent.

Nor have depot prices escaped the impact of OBRA 90, despite the fact that they are exempt from Medicaid rebate calculations. According to VA officials, VA depot prices for brand name drugs and biologicals increased over 12 percent during fiscal year 1991, nearly three times the average rate of increase for fiscal years 1988–1990. The increases in depot prices suggest that manufacturers' efforts to shift costs from Medicaid to other buyers may extend beyond an attempt to avoid providing Medicaid with "best prices" in line with pre-OBRA 90 FSS prices.

The impact of post-OBRA 90 price increases on VA's costs for pharmaceuticals has been particularly acute because the enactment of OBRA 90 coincided with the end of a multi-year FSS contract cycle. Most FSS contracts expired on December 31, 1990, the

day before the Medicaid outpatient prescription drug rebate program went into effect. In response to VA and DoD's need to stockpile drugs and biologicals to treat potential casualties of Operation Desert Storm, most manufacturers voluntarily extended prices under expiring FSS contracts through March 31, 1991. These actions delayed dramatic increases in FSS prices for many drugs and biologicals.

While the Committee is most familiar with the impact of dramatic drug price increases on VA, the Committee has received information that DoD and PHS also have experienced serious difficulties in coping with price increases. Since both DoD and PHS purchase many drugs and biologicals through the FSS, they have encountered the same price increases as VA for those products. Also, both DoD and PHS have experienced significant increases in prices for drugs and biologicals purchased through their depots.

Since the enactment of OBRA 90, VA has made extensive efforts to control pharmaceutical costs through management initiatives. VA officials have negotiated depot and single-award contracts—which are exempt from Medicaid best-price rebate calculations under OBRA 90—for several drugs and biologicals previously purchased solely through the FSS. Individual VAMCs have instituted more rigid controls over physicians' prescribing practices, mandating use of generics and therapeutic equivalents in many circumstances.

Some of these actions constitute prudent and appropriate efforts to manage scarce resources. Others raise questions about the ability of individual VA medical centers to furnish high-quality health-care services under post-OBRA 90 budget constraints. The Committee knows of at least two VA medical centers that attempted to control pharmaceutical costs by substituting a less expensive combination drug for certain high-cost drugs used to treat hypertension. Not only has this combination drug been found to be less effective, it also is known to produce more serious side effects that may discourage patient compliance with the regimen that the physician prescribes. Also, at least one VA medical center has limited the number of patients receiving kidney dialysis due to the high cost of erythropoietin, a genetically-engineered drug used to treat the anemia brought about by kidney dialysis and other medical treatments. In addition, the Committee knows of several VA facilities that allowed their inventory of some pharmaceuticals to be depleted at the end of fiscal year 1991. Such practices are clearly unacceptable.

The impact of drug price increases on VA is not confined to its pharmacies. Many VA facilities are coping with increases in pharmaceutical costs by diverting to drug purchases funds from other aspects of their operations. Responses received by the House Committee on Veterans' Affairs to its 1992 survey of VA health-care facilities indicate that, partly as a response to the increased costs of drugs and biologicals, some VA facilities have reduced their outpatient rolls, canceled some outpatient clinics, instituted hiring freezes, and delayed maintenance projects or the procurement of needed medical equipment; other facilities are reportedly planning such actions. Such actions mean longer waiting times for scheduled appointments or loss of access to VA health-care services for the

individual veteran, fewer nurses on inpatient wards to respond to patient needs, and continued use of worn-out or out-dated medical equipment. Because reduction of discretionary workload is one of VA's most widely utilized methods for reducing expenditures, the situation is particularly serious for veterans who are eligible for, but not entitled to, the VA health-care services they have received in the past and who otherwise may not have access to such services.

The Committee notes that some pharmaceutical manufacturers have suggested that the increase in VA's costs for pharmaceuticals may be due to increased utilization of pharmaceuticals rather than increases in prices. Data on VA's utilization of pharmaceuticals indicates that this is not the case. Unlike the total number of Medicaid beneficiaries, which has increased as a result of legislation enacted as part of OBRA 90 that expanded entitlement to Medicaid, the total number of veterans receiving VA health-care services has decreased slightly since the enactment of OBRA 90. In addition, according to VA officials, although VA's outpatient pharmacy workload increased 0.1 percent during fiscal year 1991, that slight increase was offset by an 8-percent decrease in inpatient pharmacy workload during that period. Indeed VA's utilization of some high-priced pharmaceuticals appears to have decreased significantly because VA health-care facilities have substituted lower-priced generics and therapeutic equivalents.

Previous legislation

In July 1991 the Senate Appropriations Committee, concerned about the impact of increases in pharmaceutical costs on VA's medical care budget, reported a provision which, after amendment in conference, was enacted as section 519(a) of the fiscal year 1992 VA–HUD Appropriations Act, Public Law 102–139. That provision exempted FSS prices from Medicaid best-price rebate calculations through the earlier of June 30, 1992, or the enactment of legislation regarding VA prices. The intent of that legislation was to facilitate temporary reductions in FSS prices until a permanent legislative solution could be enacted.

However, according to a July 28, 1992, VA report on the impact of section 519(a), it did not produce significant reductions in VA's pharmaceutical costs. Only one pharmaceutical manufacturer provided significant reductions in prices for drugs and biologicals widely utilized by VA health-care facilities as a result of that provision. Furthermore, even though that one manufacturer did provide significant reductions in the prices charged for its products during the period that the temporary exemption was in effect, net increases in prices for some of its products remained quite dramatic—more than 600 percent over the September 1990 FSS price in one case. Moreover, since section 519(a) expired on June 30, 1992, that manufacturer and several others have discontinued selling through the FSS many of the drugs and biologicals it manufactures.

Even though these drugs and biologicals—with the exception of certain oncology agents—are available through VA depots, removing products from the FSS may still have serious consequences for VA's pharmaceutical costs. The Committee has received reports

that VA health-care facilities do not always receive shipments of drugs or biologicals from VA depots in a timely fashion. If a drug or biological is available only through VA depots, a VA health-care facility may be forced to purchase the drug or biological on the open market at a price considerably higher than the FSS or depot price. Moreover, certain drugs and biologicals having a short shelf-life are not suitable for procurement through depots.

Other manufacturers have voluntarily extended reductions in prices for certain drugs and biologicals that VA does not purchase in large quantities. Although the Committee appreciates the actions of these manufacturers, it notes that VA has no guarantee as to how long these price reductions will remain in force. Moreover, reductions in prices for drugs and biologicals that VA rarely utilizes are of little consequence for VA's total expenditures for pharmaceuticals.

Need to exempt FSS prices from Medicaid best-price rebate calculations

The Committee notes that the Committee bill is only one part, albeit a large part, of the solution required to ensure that VA and other federal agencies have access to reasonable prices. The other integral part of the solution is an exemption of FSS prices from Medicaid best-price rebate calculations. Without an exemption it will be difficult to require manufacturers to sell drugs and biologicals through the FSS in accordance with the pricing mechanisms specified in this legislation. Many manufacturers have claimed that they cannot afford to provide Medicaid, which constitutes between 13 and 15 percent of the U.S. market for pharmaceuticals, the same deep discounts they provided through FSS to VA, DoD, PHS, and Bureau of Prisons health-care facilities, which, combined, total approximately 3 percent of the market. Exempting FSS prices from Medicaid best-price rebate calculations would facilitate the restabilization of FSS prices at pre-OBRA 90 levels without forcing manufacturers to provide the same discounts to Medicaid. -

The Committee notes that any changes to the Medicaid rebate program fall under the jurisdiction of the Finance Committee. Thus, the Committee is working with Senator Lloyd Bentsen, Chairman of the Finance Committee, to develop legislation that would exempt FSS prices from Medicaid best-price rebate calculations and provide an appropriate offset for costs Medicaid may incur as a result of the exemption. One alternative would be to increase the Medicaid minimum rebate percentage by an amount sufficient to offset the estimated $40 million cost of the FSS exemption. However, the Committee is willing to consider any other proposals developed by the Finance Committee that would yield equivalent savings for the Medicaid program.

With regard to Finance Committee action on an exemption of FSS prices from Medicaid best-price rebate calculations, Senator Bentsen stated in an August 6, 1992, letter to Senator Rockefeller,

> I endorse the "two-track" approach you are taking with regard to the introduction of legislation. The use of the two-track approach will enable the Finance Committee to address the question of exempting VA prices from the

> Medicaid "best price" calculation, while the Committee on Veterans' Affairs or another appropriate committee will have the opportunity to consider legislation relating to the Department of Veterans Affairs and other Federal agencies.

Senator Bentsen went on to state, "I continue to support an exemption of VA prices from the Medicaid best price calculation." The Committee notes that the Finance Committee plans to hold a markup on health-care legislation within one week of the filing of this report and that Senator Rockefeller is working with Senator Bentsen to secure Finance Committee action at that markup on legislation exempting FSS prices from Medicaid best-price rebate calculations.

The Committee expects that, as a result of such an exemption of FSS prices from the Medicaid best-price rebate mechanism, prices paid for drugs and biologicals under contracts that reference FSS prices as a basis for rebates or discounts would not be used to calculate Medicaid best-price rebates. For example, at least one State program, New York's Elderly Pharmaceutical Insurance Coverage (EPIC) program, enacted under New York Executive Laws, section 547–j (McKinney 1992), uses FSS prices as a basis for calculating rebates and discounts for drugs and biologicals dispensed to beneficiaries of its outpatient drug reimbursement program. If EPIC prices were to continue to be used as a reference for calculating Medicaid best-price rebates, the FSS price would remain the de facto Medicaid best price for those drugs and biologicals for which the FSS price is the lowest price. Such a result could undermine the Committee's goal that VA officials and manufacturers negotiate the lowest possible prices for all drugs and biologicals procured through the FSS. In order to ensure that FSS prices do not indirectly become the basis for best-price calculations, the Committee encourages the Finance Committee, in its drafting of the FSS exemption, to include a provision similar to that found in section 215 of S. 869 as passed by the Senate on November 20, 1991.

Committee bill

Legislative action clearly is needed to reverse the unintended, adverse impact of the Medicaid rebate program on VA. Deputy Secretary Anthony J. Principi articulated the scope of the problem in his testimony before the House Committee on Veterans' Affairs at its September 11, 1991, hearing on legislation dealing with this issue, H.R. 2890, as follows:

> Without some relief, additional funding relief, it will mean the curtailment of some services throughout the Nation * * * outpatient care, inpatient care, longer waiting lines. Clearly, hospital directors will have to make decisions on how to manage their facilities, and without the dollars to buy the drugs, they are going to have to cut back on the delivery of health care. * * * I have spoken with enough hospital directors now whom I respect, who tell it straight to me, that we're getting hurt by this legislation and ultimately veterans are getting hurt because they're going to be denied care. That's the bottom line.

The Committee shares Deputy Secretary Principi's concerns regarding additional funding for drug and biological purchases. In its March 4, 1992, report to the Budget Committee regarding VA's budget for fiscal year 1993, the Committee recommended the appropriation of $96 million in additional funds to offset two-thirds of the $93 million in increased pharmaceutical costs that VA officials attributed to OBRA 90 and the additional $30 million needed for the purchase of expensive, new bio-engineered drugs. However, neither H.R. 5679, the fiscal year 1993 VA, HUD, and Independent Agencies appropriations bill, as passed by the House nor the bill as reported by the Senate Appropriations Committee proposed the appropriation of sufficient funds to ensure that $96 million in additional funds will be available for pharmaceutical purchases. In these times of tight budget constraints, the Committee is concerned that Congress will be unable to supplement VA's budget at the levels necessary for VA to absorb dramatic increases in prices for drugs and biologicals without further erosion of direct patient care services.

Sections 602 through 604 of the Committee bill contain three main types of provisions designed to address different aspects of the complex relationship between the pharmaceutical marketplace and VA spending. First, the legislation contains a strong mechanism to ensure that manufacturers provide discounts to the Federal Government for drugs and biologicals sold through the FSS, VA depots, and DoD depots. Second, other provisions of the legislation would establish price-discount and inflation-protection mechanisms that would provide these agencies with discounts comparable to the rebates established under the Medicaid prescription drug rebate program. Third, additional provisions would establish new purchasing mechanisms which would enable State Veterans Homes and other Federal, State, county, and municipal entities that furnish health-care services to purchase drugs and biologicals at lower cost by combining their purchases to negotiate volume discounts.

The Committee believes that the comprehensive approach embodied in this legislation constitutes the most effective means for ensuring that VA can negotiate reasonable prices for drugs and biologicals. As VA's experience under the temporary best-price exemption has demonstrated, legislation which lacks a mechanism to require manufacturers to sell to VA at reasonable prices probably will fail to achieve that goal. The pharmaceutical industry is partially immune to many of the market forces which promote price competition in other industries. There are many drugs and biologicals for which no generic or therapeutic equivalents are available. Even when similar drugs and biologicals are available, there are limits to the appropriateness of substituting one drug for another. For example, three drugs have been approved by the Food and Drug Administration for treatment of AIDS—AZT, DDC, and DDI—but neither DDC nor DDI appears to be as effective as AZT in most cases. VA, which furnishes care to approximately 7 percent of the nation's AIDS caseload, has no choice but to purchase large quantities of AZT, regardless of its cost.

The Committee notes that some manufacturers have argued that Congress need only exempt FSS prices from Medicaid best-price rebate calculations to restore VA's ability to negotiate significant

discounts for drugs and biologicals. The Committee cannot agree. VA's share of the U.S. pharmaceutical market—approximately 1 percent—is too small to provide a strong incentive for manufacturers to lower their prices to VA. Unless VA's market share is combined with that of other federally-funded health-care programs, theoretical market forces are not likely to be sufficient to ensure that VA is charged reasonable prices for, and has access to, all the drugs it needs. By requiring manufacturers wishing to sell to any federal purchaser to provide reasonable prices to all federal purchasers, the Committee bill should restore VA to the reasonable-drug-price situation it had prior to the enactment of OBRA 90. The Committee notes that the legislation would not preclude VA officials and manufacturers from negotiating discounts greater than 24 percent. Indeed, the Committee expects VA officials to strive to negotiate the lowest possible prices for all drugs and biologicals purchased by VA facilities.

Two other features of the Committee bill—the minimum-percentage-discount and the additional-price-discount mechanisms—are designed to provide VA and DoD with additional tools for obtaining reasonable prices that are comparable to the tools provided to the Medicaid program under OBRA 90.

Thus, the legislation would establish a 24-percent minimum discount (off the Federal average manufacturer price—a weighted average price for a single form and dose unit that wholesalers paid to the manufacturer) for single source and innovator multiple source drugs and biologicals. The reasons for establishing a minimum percentage discount are twofold. First, it would ensure that manufacturers will once again provide discounts for drugs and biologicals purchased through the FSS and VA depots. Prior to the enactment of OBRA 90, FSS and VA depot prices were the best or among the best prices available to any purchasers. Without a legislative remedy, such as the enactment of a minimum percent discount, there can be no guarantee that VA will once again be able to purchase drugs and biologicals through FSS and VA depots at reasonable prices. The Committee believes that the establishment of a minimum percentage discount for FSS and VA depots is consistent with the basic rebate provisions of the Medicaid rebate statute, which require manufacturers to provide rebates to Medicaid equal to the lesser of the best price available to any other purchaser or a minimum percentage discount (12.5 percent in 1992 and 15 percent thereafter).

Second, this minimum-percentage-discount mechanism would also ensure that VA receives discounts for drugs and biologicals approved since the enactment of OBRA 90. During the coming years, increasing numbers of expensive, genetically-engineered drugs are expected to be approved by FDA. For example, within the next year, the Federal Drug Administration is expected to approve a monoclonal antibody, known as HA–1A, to treat gram-negative sepsis, an infection common among patients in intensive-care units. VA officials estimate that use of this potentially life-saving drug could cost $60 million per year. Because no therapeutic equivalents are likely to be available for many of these genetically-engineered drugs legislation should be enacted to provide VA with minimum price discounts. The Committee believes that a minimum percent-

age discount is necessary to ensure that VA and other federal agencies have access to prices for drugs and biologicals that are equal to or lower than the net prices calculated under the Medicaid rebate program.

The minimum percentage discount contained in the Committee bill reflects the Congressional Budget Office's estimate of the median percentage discount received by the Medicaid program during the first quarter of calendar year 1991 under the OBRA 90 best-price and minimum-percentage-discount mechanisms. For drugs and biologicals for which pre-OBRA 90 prices are not available for use as a benchmark, the median Medicaid discount for the first quarter of calendar year 1991 represents the closest possible approximation to pre-OBRA 90 discount levels. Since that time, the "best prices" for many drugs and biologicals have increased significantly, causing Medicaid's median percentage discount to decrease. In light of the need to stabilize FSS and depot prices at pre-OBRA 90 levels plus inflation, the Committee views the use of this percentage as most appropriate. VA pharmacy officials estimate that a 24-percent discount likely would enable VA to counter the increased costs the Department is incurring as a result of price increases that the Department has experienced since OBRA 90.

Another feature of the Committee bill, the additional price discount, is similar to a provision of the Medicaid rebate statute, the "additional rebate mechanism." The additional-price-discount mechanism would increase the minimum percentage discount for a drug or biological by an amount equal to the difference, if any, between the increase in the Federal average manufacturer price for the drug or biological and the increase in the Producer Price Index-Finished Goods during the 12 months prior to a manufacturer's entering into an FSS, VA depot, or DoD depot agreement. The net effect of the additional price discount mechanism is to contain the rate of inflation in pharmaceutical prices by providing manufacturers with a disincentive to increase their prices to VA at rates greater than the general rate of inflation.

Other provisions of the Committee bill establish specific, fixed standards for FSS, VA depot, and DoD depot prices and ensure that future increases in such prices would not exceed increases in the general rate of inflation. Some manufacturers have questioned the Committee's decision to establish such stable criteria upon which future price increases would be based. The Committee considers such criteria necessary to ensure that the Committee bill does not perpetuate a flaw of the Medicaid prescription rebate program as enacted in OBRA 90. Under OBRA 90, Medicaid's best-price rebate for a drug or biological is determined on the basis of the manufacturer's price at the time of the rebate. In order to reduce the amount of these rebates, many manufacturers have eliminated or reduced the discounts they previously provided to the FSS and certain non-federal bulk purchasers. Such actions precipitated significant increases in these purchasers' prices and may reduce the total savings Medicaid will achieve through the rebate program. Manufacturers would not have been able to do that if a benchmark had been established to serve as a basis for Medicaid best-price rebate calculations, as was proposed in the original Medicaid rebate legislation introduced by Senator Pryor and Represent-

atives Wyden and Cooper (noted above) but not included in the final OBRA 90 Medicaid rebate provisions. The Committee notes that the Department of Health and Human Services Inspector General recommended in an September 25, 1991, report that HHS submit to Congress a legislative proposal to establish a pre-OBRA 90 benchmark for Medicaid's "best prices" and restrict future increases in those prices to increases in the general rate of inflation.

Although the main thrust of title VI of the Committee bill is to ensure that VA has access to reasonable prices, it also contains provisions that would assist State Veterans Homes and other federal, State, county, and municipal health-care facilities. Sections 605 and 606 of the legislation would improve State Veterans Homes' access to discounted prices, by authorizing them to purchase drugs and biologicals at FSS prices and to participate in the Unified Pharmaceutical Award Contracts established in section 606 of the Committee bill.

Under VA's State Veterans Home program, States receive grants from VA for the construction, expansion, or remodeling of facilities that furnish long-term care services to veterans. VA also makes per diem payments to State Veterans Homes for care furnished to eligible veterans. There are currently a total of 51 State Veterans Homes operated by 34 States. Because VA does not operate a sufficient number of nursing-home and domiciliary-care facilities to meet veterans' needs for such care, State Veterans Homes are an integral and cost-effective part of the effort to meet veterans' long-term care needs.

According to the National Association of State Veterans Homes (NASVH), many State Veterans Homes have had to cope with significant drug price increases since the enactment of OBRA 90. Most are freestanding facilities that are too small to negotiate discounts for drug and biological purchases on their own. In light of the importance of the State Veterans Home program to the national effort to meet veterans' health-care needs, the Committee believes that the homes should be able to purchase drugs and biologicals at the same prices as those paid by VA health-care facilities.

Access to FSS prices should enable State Veterans Homes to reduce their expenditures for drugs and biologicals. Although the differentials between current FSS prices and State Home prices vary considerably from drug to drug, the results of a survey completed by NASVH at the Committee's request suggest that savings for some drugs and biologicals would be significant. For example, the current FSS price for a 60-tablet bottle of Zantac, the most widely-prescribed drug in the United States for treatment of ulcers and one of the drugs most frequently prescribed to State Home residents, is equivalent to $0.71 per tablet. According to the NASVH survey, State Home prices for Zantac are considerably higher than the FSS price. The 27 State Homes that provided unit price information for Zantac pay prices ranging from $0.89 to $1.31.

Section 606 of the Committee bill also could benefit State Veterans Homes. That section would authorize the Secretary of Veterans Affairs to negotiate pharmaceutical contracts, referred to as unified pharmaceutical award contracts (UPACs), on behalf of VA and other federal, State, county, and municipal health-care entities that procure drugs and biologicals. The UPAC provisions are de-

signed to encourage governmental entities to utilize purchasing practices similar to those utilized by non-governmental purchasers to achieve significant price discounts. Under a UPAC, the market shares of various governmental health-care programs would be combined to form a buying group that would commit to purchasing a large quantity of a drug or biological. To prevent UPACs from imposing additional burdens on VA's budget for pharmaceuticals, the legislation would require entities participating in a UPAC to pay VA a contract user fee to offset the administrative costs of negotiating and administering a UPAC. The Committee notes that UPAC prices would be freely negotiated between the Secretary and manufacturers and, thus, would not be subject to 24-percent minimum discount that the Committee bill mandates for FSS and depot prices.

Cost

According to CBO, enactment of title VI of the Committee bill could yield savings of $40 to $60 million per year for VA and $30 to $40 million per year for DoD for drugs and biologicals purchased through the FSS. Purchases made through the FSS constitute approximately 50 percent of VA's total expenditures for drugs and biologicals. CBO has made no estimate of savings resulting from the enactment of provisions relating to prices for drugs and biologicals purchased through VA depots, which constitute for approximately 25 percent of VA's total expenditures for drugs and biologicals. CBO also estimates that enactment of title VI would yield savings in direct spending under the Medicaid program of $30 million in budget authority and outlays in FY 1993 and $820 million in budget authority and outlays in FYs 1993–1997. With respect to the estimated savings in the Medicaid program the Committee notes that these savings—which would, under CBO's analysis, be the result of the use of the lower FSS prices in the best price calculations—would be eliminated by legislation that the Committee expects the Finance Committee to report soon exempting the Federal Supply Schedule from Medicaid best-price rebate calculations.

TITLE VII—MISCELLANEOUS

Respite care

Section 701 of the Committee bill would make permanent VA's authority to furnish respite care to veterans eligible to receive VA hospital, nursing home, or domiciliary care.

Section 201 of Public Law 99–576, enacted on October 28, 1986, provided VA with express statutory authority to provide respite-care services to veterans eligible to receive hospital or nursing home care. Respite care, for this purpose, is defined as hospital or nursing home care which (1) is of limited duration; (2) is furnished in a VA facility on an intermittent basis to a veteran who is suffering from a chronic illness and who resides primarily at home; and (3) is furnished for the purposes of helping the veteran to continue residing primarily at home.

The authority, initially enacted as a pilot program set to expire on September 30, 1989, was twice extended, by Public Laws 101–237

and 102–83, and is currently scheduled to expire on September 30, 1992.

The goal of respite care is to help maintain individuals with serious chronic illnesses in their homes as long as possible before having to resort to institutional care. It is widely agreed that, where it is medically feasible, maintaining a person at home is better for an ill person's overall health status and is a far more efficient and cost-effective way to meet his or her health-care needs than is institutionalization. Very often a factor critical to a person's ability to remain at home is the regular availability of a spouse, child, or other relative or close friend to provide meal, homemaker, and other person-care services that, combined with outpatient treatment, home-health services, or other sources of medical attention, meet the individual's full range of needs.

Respite care aims to provide the primary caretaker with a break from the overwhelming responsibilities of caring for a chronically ill loved one and thus to make the caregiver more likely to be able to provide services for a longer period of time. VA, in its 1990 "Report on the Respite Care Program," stated, "A critical element of the respite arrangement is that the respite is planned in advance for the benefit of the caregiver, rather than being incidental to the provision of necessary medial care of the patient."

The VA report, written pursuant to a requirement of Public Law 99–576, declared the program a success in terms of caregiver satisfaction and cost effectiveness and forecast considerable growth in the program. According to the President's fiscal year 1993 budget submission to Congress, in fiscal year 1992, VA operated respite-care programs at 118 VA medical centers at a cost of $18.1 million and anticipates continuing with a requested 6.4 percent budget increase.

Section 701 of the Committee bill would amend section 1720B of title 38 to delete the subsection providing for a termination date for the program of September 30, 1992.

Cost

According to CBO, the enactment of section 701 of the Committee bill would entail costs of $26 million in budget authority and outlays in fiscal year 1993 and total costs of $148 million in budget authority and outlays in fiscal years 1993–1997.

Extension of authority to enter into contracts with respect to the Veterans Memorial Medical Center in the Philippines

Section 702 of the Committee bill would extend for four years and three months, through December 31, 1996, VA's authority to enter into contracts with the Veterans Memorial Medical Center (VMMC) in the Philippines for the United States to provide for payments for hospital care and medical services furnished to eligible United States veterans.

In 1948, Public Law 80–865 provided for the funding of the construction and equipping of a medical center in Manila for the care of U.S. veterans in the Philippines. According to the VA Regional Office in Manila, there were approximately 187,000 individuals eligible for VA care in the Republic of the Philippines in 1986 (the most recent year for which this information is available), including

U.S. veterans and veterans of the Commonwealth Army and the New Philippine Scouts.

Currently, under section 1732(a) of title 38, authority to contract with the VMMC for the furnishing of care to United States veterans is scheduled to expire on September 30, 1992. The Committee bill would extend that authority through calendar year 1996.

Cost

According to CBO, enactment of this provision would entail costs of $3 million in budget authority and outlays in fiscal year 1993 and total costs of $16 million in budget authority and outlays in fiscal years 1993–1997.

Waiver of Federal limitation on retirement pay

Section 703 of the Committee bill would make permanent VA's authority to waive the restrictions in section 5532 of title 5, United States Code, on the receipt of military retirement pay by a reemployed retiree where necessary to meet special or emergency needs for registered nurses (RNs) resulting from a critical shortage of well-qualified candidates.

Section 5532 of title 5 generally places certain limits on the concurrent receipt of both retirement pay or a retirement annuity and a federal salary. Thus, when an individual receiving military retirement pay takes a position with VA, he or she does not receive the full sum of the retirement benefit and the VA salary. The waiver authority enables VA to overcome this obvious deterrent to VA employment.

Use of the waiver authority has enabled VA to recruit military retirees to fill RN vacancies for which VA has experienced serious recruitment difficulties, especially certified registered nurse anesthetist vacancies at rural VA medical centers. Although in the two years since the authority was granted, VA has used it only 6 times, VA testified to the Committee at its June 3, 1992, hearing that its use clearly was necessary in those cases.

VA already has permanent authority, in section 7426(c) of title 38, to waive military retirement pay restrictions to meet special or emergency needs for physicians.

Cost

According to CBO, enactment of section 703 would entail costs of less than $500,000 in fiscal year 1993.

Health Professional Scholarship Program

Section 704 of the Committee bill would extend for five years, until December 31, 1997, VA's authority to carry out the Department of Veterans Affairs Health Professional Scholarship Program.

The Health Professional Scholarship Program is one of the three components of VA's Health Professionals Educational Assistance Program (chapter 76 of title 38, United States Code), the other two being the Tuition Reimbursement Program and the Reserve Member Stipend Program. The purpose of these program is to ensure an adequate supply of trained health-care professionals for

VA and the nation. The Scholarship Program, authorized by Public Law 96–330 in 1980, was first implemented in fiscal year 1982.

Congress has modified the qualifications for receipt of scholarships over the years. Originally scholarships were available to students for education or training for employment as a physician, dentist, podiatrist, optometrist, nurse, physician assistant, or expanded function dental auxiliary. In fiscal year 1988, eligibility was extended to study towards employment as a physical therapist and, in fiscal year 1990, occupational therapy and associate degree nursing students were added.

Scholarship Program participants are provided with payment of tuition, other reasonable education expenses, and a stipend. For each year's scholarship received, the participant is obligated to work for VA for one year in a full-time capacity in a health-care position in an assignment or location determined by the Secretary.

The Health Professional Scholarship Program, although authorized for other professions, has been used to provide scholarships only to students studying for associate, baccalaureate and master degrees in nursing and baccalaureate and master degrees in physical or occupational therapy. According to VA's "Fourth Annual Report on the Health Professional Educational Assistance Program," dated January 1992, there have been 2,866 scholarship recipients, including 741 currently pursuing studies. In fiscal year 1991, scholarships were provided to 445 nursing students, 37 occupational therapy students, and 36 physical therapy students. A little over $10 million was obligated for these awards in fiscal year 1991, an average of $19,342 per participant.

In its 1992 report VA concluded, "These programs are having a positive impact on recruitment and retention of nurses, occupational therapists, and physical therapists in the Department of Veterans Affairs."

Section 704 of the Committee bill would amend section 7618 of title 38 to change the termination date of the authority to furnish scholarships to new participants in the Scholarship program from September 30, 1992, to December 31, 1997.

Cost

According to CBO, enactment of this provision would entail estimated costs of $10 million in budget authority and no outlays in fiscal year 1993 and total costs of $56 million in budget authority and $40 million in outlays in fiscal years 1993–1997.

Permanent authority to make grants to States relating to State homes

Section 705 would make permanent VA's authority to make grants to States for the construction or renovation of State veterans home facilities.

In addition to making per diem payments to States for care of veterans in State veterans home facilities, VA provides grants to States to cover up to 65 percent of costs for the construction or renovation of facilities for furnishing hospital, nursing home, or domiciliary care to veterans in State veterans homes. There are now 65 State Veterans Home facilities in 38 States. Annual appropriations for these matching-fund grants for fiscal year 1987 through fiscal

year 1990 ranged from $40.32 million (for fiscal year 1988) to $42.4 million (for fiscal year 1987). For fiscal year 1991, the appropriation was $70 million. Because of a great backlog in approved but unfunded State projects, Congress appropriated a substantially greater amount, $85 million, for fiscal year 1992.

The Committee believes that the State Home program is an effective way to provide long-term care services to veterans across the United States. The per diem rates are well below the average daily cost of care in a VA-operated extended-care bed.

Cost

According to CBO, enactment of section 705 of the Committee bill would entail costs of $88 million in budget authority and no outlays in fiscal year 1993 and total costs of $470 million in budget authority and $241 million in outlays in fiscal years 1993–1997. However, the Committee notes that the Administration has requested an fiscal year 1993 appropriation of only $40 million for this program and that the Committee does not expect the Congress to increase that figure.

Cost Estimate

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (CBO), estimates (a) that during fiscal year 1993 and for the first 5 years following enactment the cost in direct VA spending resulting from the enactment of the Committee bill would be $1 million in budget authority and outlays in fiscal year 1993 and $1 million in budget authority and outlays every fiscal year thereafter through fiscal year 1997; (b) that during fiscal year 1993 and for the first 5 years following enactment the cost in discretionary VA spending resulting from the enactment of the Committee bill would be $135 million in budget authority and $34 million in outlays in fiscal year 1993; $142 million in budget authority and $60 million in outlays in fiscal year 1994; $150 million in budget authority and $106 million in outlays in fiscal year 1995; $149 million in budget authority and $135 million in outlays in fiscal year 1996; and $155 million in budget authority and $149 million in outlays in fiscal year 1997; and (c) the savings in direct spending under the Medicaid program would be $30 million in budget authority and outlays in fiscal year 1993; $100 million in budget authority and outlays in fiscal year 1994; $180 million in budget authority and outlays in fiscal year 1995; $240 million in budget authority and outlays in fiscal year 1996; and $270 million in budget authority and outlays in fiscal year 1997. CBO further estimated that enactment of the provisions of title VI of the Committee bill could yield savings of $40 to $60 million per year for VA and $30 to $40 million per year for DoD for drugs and biologicals purchased through the FSS. With respect to the estimated savings in the Medicaid program, the Committee notes, as indicated earlier in the "DISCUSSION" section of this report, that these savings—which would, under CBO's analysis, be the result of the use of the lower FSS prices in the best price calculations—would be eliminated by legislation that the Committee expects the

Finance Committee to report soon exempting the Federal Supply Schedule from Medicaid best-price rebate calculations. The cost estimate provided by CBO, setting forth a detailed breakdown of the costs follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 15, 1992.

Hon. ALAN CRANSTON,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate of S. 2575, the Veterans Health Programs Improvement Act of 1992, as ordered reported by the Senate Committee on Veterans' Affairs on August 7, 1992.

The bill would affect direct spending and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER,
Director.

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 2575.

2. Bill title: Veterans Health Programs Improvement Act of 1992.

3. Bill status: As ordered reported by the Senate Committee on Veterans' Affairs, August 7, 1992.

4. Bill purpose: To revise certain pay authorities that apply to nurses and other health-care professionals in the Department of Veterans Affairs (VA), and for other purposes.

5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Direct spending:					
Function 700:					
Budget authority	1	1	1	1	1
Outlays	1	1	1	1	1
Function 550:					
Budget authority	−30	−100	−180	−240	−270
Outlays	−30	−100	−180	−240	−270
Total direct spending:					
Budget authority	−29	−99	−179	−239	−269
Outlays	−29	−99	−179	−239	−269
Authorizations:					
Function 700:					
Estimated authorization level	135	142	150	149	155
Estimated outlays	34	60	106	135	149

Basis of estimate: The following section-by-section cost analysis addresses only those sections of the bill that could be expected to have a significant budgetary impact.

TITLE I

Section 101

This section would increase the number of pay grades for VA nurses from four to five. Under current law, the pay grades are identified as director grade, senior grade, intermediate grade, and entry grade. Under section 101, the pay grades would be identified only as numerical levels, for example, Nurse I, Nurse II, and so forth.

While the addition of a pay grade would allow VA to increase the salary level of some nurses, the proposed change, in and of itself, would not compel VA to alter the salary of any nurse. Furthermore, because the pay grade titles are removed by the provision, it is not possible to determine where in the schedule the new grade would be added.

Section 102

Under current law, the director of each VA medical facility must periodically adjust the rates of pay for the facility's nursing staff to maintain comparability with nurses' pay in the local labor market. This section would exempt nurses at VA facilities outside the contiguous United States, Alaska, and Hawaii from the market comparability adjustment.

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Estimated authorization level	(1)	1	1	2	2
Estimated outlays	(1)	1	1	2	2

[1] Less than $500,000.

This provision would affect 393 nurses at the VA medical center in San Juan, Puerto Rico and 1 nurse at the Veterans Memorial Medical Center in Manila, Republic of the Philippines. VA has frozen the salaries of these nurses, except for cost-of-living increases. Under current law, no real increase in a nurse's salary can be granted except through the comparability adjustment, which would indicate that salaries of these nurses should be reduced. Because of the exemption from comparability adjustment, the above estimate assumes that real growth of 3 percent a year in salaries—the level of a step increase under the General Schedule—would be provided under this section.

TITLE II

This title would repeal the VA pilot program for the provision of preventive health-care services and would expand VA's permanent authority to provide such services by including them under the definition of "medical services". The title would also establish within the VA a National Center for Preventive Health and would author-

ize for each fiscal year after 1992 the appropriation of $2.5 million for the operation of the Center.

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Authorization level	3	3	3	3	3
Estimated outlays	2	2	3	3	3

VA has expanded the Preventive Health-Care Pilot Program to the extent that they now operate "a preventive medicine program at each VAMC [Department of Veterans Affairs Medical Center] and independent outpatient clinic.[1] Thus, it is not expected that giving permanent status to the pilot program would significantly increase VA spending on preventive health-care services.

The estimate above represents the cost attributed to the establishment of the National Center for Preventive Health. It was assumed that the amounts authorized by the bill would be fully appropriated. Outlays were assumed to occur somewhat slower in the first two years as the Center is being organized. In later years, outlays were estimated according to the historical spending pattern for activities of this sort.

TITLE III

This title would provide that remuneration from work therapy programs operated by state veterans' homes would not be considered income for VA pension purposes. Payments from such programs operated by, or within, VA facilities are exempt under current law.

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Budget authority	1	1	1	1	1
Outlays	1	1	1	1	1

According to the National Association of State Veterans' Homes, 25 state homes offer compensated work therapy (CWT) programs. Because nationwide data were not available on the number of pensioners participating in these programs, the above estimate is based on information from a sampling of six state homes with large CWT programs.

It is estimated that around 400 pensioners participate in such CWT programs. It is also estimated that, on the average, these participants work around 14 hours per week. Payment at the federal minimum wage level would, therefore, provide pensioner-participants with reportable income of around $3,000 a year. Exclusion of this income from pension consideration would increase the veteran's pension payment by an equal amount.

[1] Department of Veterans Affairs, "Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1991," p. 12.

TITLE IV

This title would expand the VA program of rural health-care clinics by adding authority for part-time stationary clinics to the current authority for mobile clinics. Title IV would require VA to operate at least 3 rural clinics and would authorize the appropriation of $3 million in 1993, $6 million in 1994, and $9 million in 1995 for this activity.

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Authorization level	3	6	9	0	0
Estimated outlays	1	2	6	7	2

In the past, spending for the acquisition and operation of mobile clinics in rural areas has been very slow. Three million dollars was appropriated for mobile clinics in both 1989 and 1990. Nonetheless, the first mobile clinic was not ordered until late in 1991 and is not expected to be delivered until September, 1992. However, now that the ordering procedures are established, it is expected that the acquisition of additional mobile clinics could proceed more quickly. The timetable for establishing a part-time stationary clinic should be similar to those for a satellite outpatient clinic. The above estimate assumes that the authorized amounts would be fully appropriated.

TITLE V

This title would authorize VA to install telephones in patient rooms in the VA medical centers in Philadelphia, Pennsylvania and Tucson, Arizona.

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Estimated authorization level	2	(1)	(1)	(1)	(1)
Estimated outlays	2	(1)	(1)	(1)	(1)

[1] Less than $500,000.

Telephones have been installed in patient rooms in a few VA facilities, financed by donations from veteran service organizations and other private sources. The estimate of the cost of installing and operating patient phones in Philadelphia and Tucson is based on the cost experienced in these other facilities. Major improvements would be required in the telephone lines and switching facilities for such a sizeable expansion in the number of phones in the system. The cost of such improvements is included in the estimate above. Because patients would be required to pay for all toll calls, the increase in operating costs is expected to be less than $500,000 a year.

TITLE VI

This title would establish a mechanism to control the prices paid by federal agencies to purchase drugs and biologicals from the Federal Supply Schedule (FSS). In general, the FSS price paid for a brand name drug would be limited to 76 percent of the average price paid by wholesalers. The FSS price would be further reduced to reflect the extent to which drug price increases exceed increases in the Producer Price Index. Drug manufacturers would be required to enter into pricing agreements complying with this formula in order to receive payment for drugs or biologicals under the Medicaid program or to sell drugs or biologicals to VA, the Department of Defense (DoD), the Public Health Service (PHS), or any entity that receives funds from the PHS.

CBO is unable to provide a precise estimate of the savings in the pharmaceutical costs of VA, DoD, and PHS that would result from this measure because of limitations on the data available to compare current federal drug prices to wholesale prices. Based on a comparison of 1991 FSS and wholesale prices for a sample of 24 drugs commonly used by VA, it is estimated that savings could amount to $40–60 million a year for VA and $30–40 million annually for DoD. Nevertheless, it should be noted that spending on pharmaceuticals for these agencies is financed through appropriations; and net federal savings from this provision would only occur if future appropriation levels are reduced in response to the reduction in pharmaceutical costs.

This provision would also result in savings to the Medicaid program, which is a direct spending program. Under the Medicaid prescription drug rebate provisions, the State Medicaid programs are, in effect, guaranteed drug prices no higher than those available on the FSS. Since the inception of the Medicaid rebate program, FSS prices have risen and many drugs have been removed from the FSS. Because the bill would mandate that all drugs reimbursed by Medicaid would have to be placed on the FSS with a price not to exceed 76 percent of the wholesale price, Medicaid would be guaranteed rebates of 24 percent of the wholesale price. Currently, CBO estimates that Medicaid rebates would average from 16 to 22 percent over the next five years. Therefore, rebates would be higher under the bill and net Medicaid spending on prescription drugs would be lower. CBO estimates that savings would be $30 million in 1993 and $820 million over the five-year budget period.

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Function 550:					
Budget authority	−30	−100	−180	−240	−270
Outlays	−30	−100	−180	−240	−270

TITLE VII

Section 701

This section would eliminate the sunset date on the authority of the VA to provide respite care. Respite care is inpatient care provided to an individual who is otherwise cared for at home. The purpose of respite care is to provide some relief for the caregiver.

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Estimated authorization level	26	27	29	32	34
Estimated outlays	26	27	29	32	34

The authority of the VA to provide respite care expires on September 30, 1992. The agency has collected very little data on the amount of respite care that has been provided in the past or on the cost of that care. VA estimates that there is an average daily census of 685 respite care patients in the 137 participating VA facilities. The only data on the cost of respite care comes from a study that was done by VA in 1988. Based on this data, it is estimated that the average per diem cost for respite care in 1993 would be $103. The above estimate assumes that the number of respite care patients would remain relatively stable through the projection period and that the average cost would increase with inflation.

Section 702

This section would extend through December 31, 1996, the authority of the VA to contract with the Veterans Memorial Medical Center in Manila to provide care to U.S. veterans in the Philippines.

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Estimated authorization level	3	3	3	3	4
Estimated outlays	3	3	3	3	4

During 1991, $2.6 million was expended by VA for medical care and services provided by the Veterans Memorial Medical Center in Manila. This amount was increased for anticipated inflation to estimate future authorization levels. Outlays were estimated according to historical spending patterns.

Section 703

Under current law, retired military servicemembers who take civil service positions have their retired pay reduced. In 1991 VA was given the authority to waive this reduction in the case of VA nurses, when necessary to overcome a severe shortage of qualified candidates. Section 503 would remove the September 30, 1992, sunset date on this waiver authority.

According to VA data, this authority has been used in the case of only 6 nurses in the two years since the authority was originally granted. Therefore, it is not expected that enactment of this provision would result in a significant cost. The small cost of section 503 would be an increase in direct spending, because the increase would occur in the military retirement fund, a mandatory account. The provision would, thus, have a pay-as-you-go impact of less than $500,000.

Section 704

This section would extend through December 31, 1997, the sunset date on the authority of the VA to provide scholarships to individuals studying in the health professions. This authority expires under current law on September 30, 1992.

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Estimated authorization level	10	11	11	12	12
Estimated outlays	0	7	11	11	11

The 1992 appropriation included $10.1 million for this activity. This amount was increased for anticipated inflation to estimate future authorization levels. Outlays are projected according to historical spending patterns.

Section 705

This section would eliminate the sunset date on the authority of the VA to provide grants to states for the construction of state veterans' homes. This authority expires under current law on September 30, 1992.

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Estimated authorization level	88	91	94	97	100
Estimated outlays	0	18	53	77	93

The 1992 appropriation included $85 million for this activity. This amount was increased for anticipated inflation to estimate future authorization levels. Outlays are projected according to historical spending patterns.

6. Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1995. The bill would have the following pay-as-you-go impact:

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995
Outlays	0	-29	-99	-179
Receipts	(1)	(1)	(1)	(1)

[1] Not Applicable.

7. Estimated cost to State and local government: The Congressional Budget Office has determined that the budgets of state and local governments would not be significantly affected by the enactment of this bill.

8. Estimate comparison: None.

9. Previous CBO estimate: None.

10. Estimate prepared by: K.W. Shepherd (and) Scott Harrison.

11. Estimate approved by: C.G. Nuckols, Assistant Director for Budget Analysis.

Regulatory Impact Statement

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact which would be incurred in carrying out the Committee bill. The Committee finds that except with respect to the provisions of title VI, relating to prices paid by VA for pharmaceuticals, the Committee bill would not entail any significant regulation of individuals or businesses or result in any significant impact on the personal privacy of any individuals and that, except as noted below, the paperwork resulting from enactment would be minimal.

In the case of the provisions of title VI, the Committee bill is designed to produce certain discounts in the prices that pharmaceutical manufacturers charge VA and other federal entities that purchase through the Federal Supply Schedule (FSS) and VA and DoD depots for brand-name drugs and biologicals. According to CBO, these provisions could yield savings of $40 to $60 million per year for VA and $30 to $40 million per year for DoD for drugs and biologicals purchased through the FSS.

In the cases of provisions requiring reports to the Congress to provide program data and evaluations (sections 105, 203, 204, 205, 401, and 501), the amount of paperwork would be reasonable in light of the beneficial objectives of the legislation.

Tabulation of Votes Cast in Committee

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at meetings on June 24, 1992, and August 7, 1992. On June 24, the Committee voted by a voice vote to report S. 2575 favorably to the Senate with an amendment in the nature of a substitute and subject to any subsequently adopted amendments.

Thereafter, the Committee adopted three amendments to the bill, as follows:

An amendment proposed by Senator Cranston, derived from S. 1424 and modified by a second degree amendment offered by Senator Simpson, relating to VA rural health-care clinics, was approved by a voice vote.

An amendment proposed by Senators Specter and DeConcini relating to telephone service in VA medical center patients' rooms, was approved by a vote of 8–3, as follows:

YEAS (8)	NAYS (3)
Alan Cranston	George J. Mitchell
Dennis DeConcini	John D. Rockefeller IV
Daniel K. Akaka	Bob Graham
Thomas A. Daschle	
Arlen Specter	
Strom Thurmond	
Frank H. Murkowski	
James M. Jeffords	

At the Committee's August 7, 1992, meeting the Committee approved by voice vote, with Senator Specter expressly abstaining, an amendment offered by Senators Rockefeller, Simpson, Murkowski, and Cranston relating to prices paid for drugs and biologicals purchased through the Federal Supply Schedule, VA depots, and Department of Defense depots. The Committee also approved, by unanimous consent, an amendment offered by Senator Cranston regarding the State Home program.

Agency Reports

On March 25 and on April 22, 1992, the Committee Chairman asked the Secretary of Veterans Affairs for a report setting forth the Department's views on S. 2372 and S. 2575, respectively. As of the date of the filing of this report, reports on the Department's views on these two bills had not been received. However, on June 3, 1992, VA's Chief Medical Director, Dr. James W. Holsinger, Jr., submitted testimony on S. 1424, S. 2740, and S. 2575 as introduced and the testimony is reprinted below in lieu of Department reports on these bills. In response to a May 19, 1992, request from the Chairman, on June 23, 1992, the Department submitted a report setting forth its views on S. 2715, which is reprinted below, following Dr. Holsinger's testimony.

Statement of James W. Holsinger, Jr., M.D., Chief Medical Director, Department of Veterans Affairs

Mr. Chairman and Members of the Committee:

I am pleased to be here today to present the Department's views on three bills intended to improve the VA health care system. We support some provisions in the bills, and oppose others. We appreciate your considering our views as you review these measures.

S. 2575

Mr. Chairman, I will begin by commenting on S. 2575, your bill which contains a number of provisions which would modify our nurse pay system. The bill would also extend our authority to contract for the care of veterans in the Veterans Memorial Medical

Center in the Philippines, and permanently authorize our Health Professional Scholarship Program, our Respite Care Program, and our State Home Grant Program.

Nurse pay

S. 2575 contains eight different provisions which would modify the recently enacted locality-based nurse pay system. We believe, based on greatly improved nurse recruitment and retention, that this new system is generally successful. As a result, we must object to most of the provisions of this bill affecting nurses' pay. Before nurse pay reform, we were spending approximately $100 million on special pay for nurses; salary expenses related to nurse pay reform amount to an additional $170 million and the increase accounts for nine percent of total nurse salary expenditures. There are no systematic data available that indicate a need to further reform this pay system.

Revision of nurse pay grade schedule

Section 2 of the bill would revise the nurse pay schedule to expand it from four grades to five. In addition, the bill would eliminate the current grade titles of Entry, Intermediate, Senior and Director, and replace them with Nurse I, Nurse II, Nurse III, Nurse IV, and Nurse V.

This proposal is simply not justified at this time.

Authority to waive reduction in military retired pay

Section 3 would make permanent our authority to waive the reduction in military retired pay for nurses and nurse anesthetists. That authority expires September 30, 1992. The waiver authority is restricted to situations where its use is necessary to meet special or emergency employment needs due to a severe shortage of well-qualified candidates which otherwise cannot be met readily.

We do not support this provision. Even before nurse pay reform, we rarely used this authority. With the new pay system, we no longer believe it is necessary to maintain this authority within the VA.

Special rates of pay for Manila and San Juan

Section 4 would authorize VA to establish pay rates for covered positions at VAMC San Juan and the Manila Veterans Memorial Medical Center, separate from the locality-based nurse pay system.

We support this provision. It will provide needed additional flexibility with respect to the San Juan and Manila Medical centers. Data for comparable positions in San Juan and Manila are not available. As a result of establishing a four-grade system without local data, the following has occurred:

The pay schedules for these facilities, especially at the Intermediate, Senior, and Director enhanced qualifications or assignments (EQA) grades, have been drastically compressed.

In Intermediate grade, San Juan has 64 nurses on pay retention and 43 at the top step of the grade, with little expectation of being able to do anything to improve the situation.

Manila must attempt conducting locality pay surveys for one American nurse, knowing that there is no comparable data.

Authority to import survey data and to use contract data to set CRNA pay rates

Section 5 would authorize an additional survey method for the locality-based nurse pay system where a VAMC Director determines that neither a Bureau of Labor Statistics (BLS), nor a VA local survey of the VAMC's labor market area, provides sufficient data to adjust pay rates. The VAMC Director could conduct a survey to obtain data from a "comparable," but separate labor market area.

Section 5 also would authorize a VAMC Director to use nurse anesthetist contract agency compensation data to adjust locality-based nurse anesthetist pay rates where none of the survey methods (BLS, VA Survey, or imported survey) provides sufficient data.

Although we support flexibility for the locality-based nurse pay system, we think this additional authority is not necessary at this time. Under existing authority, we have authorized VAMC Directors, in situations where there is insufficient survey data from the immediate local area, to expand the local labor market areas until they cover a geographic area in which sufficient data is available.

We believe expansion of local labor market areas will provide sufficient data to make determinations concerning nurse anesthetist local pay rates. Moreover, we have serious concerns that contract agency data will provide a valid basis for determining VA pay rates. For example, contract agency nurse anesthetists frequently do not receive premium pay, benefits, or malpractice coverage, but must provide for their own from lump sum compensation which greatly exceeds employee salaries. In addition, nurse anesthetist agency pay practices and employee assignments frequently differ significantly from the traditional hospital employer—employee relationship.

Although we do not think that these authorities are necessary at this time, we will continue to evaluate the effectiveness of existing authorities, to fine-tune administrative practice under those authorities, and to consider development of proposals of new authorities, if necessary to assure that VA continues to recruit and retain highly qualified health care personnel.

Revision of basis for calculation of compensation of corresponding health care positions

Section 6 would change the survey process by surveying for "paid" minimum rates of pay from the current statute's "established" minimum rates. We believe that the intent of this provision is to require the use of actual minimum rates paid by competing health care facilities, as opposed to the minimum rate of their published pay schedules. We strongly oppose this provision.

In the first place, we think that this provision is designed to address a problem which has already been resolved by the use of data on actual or above-minimum rates. We have advised field facilities that in situations where competing health-care facilities were hiring at rates above the minimum published rates, to use those hiring rates for survey data. We determined that above-minimum rates are minimum "established" rates for the purpose of VA

salary surveys. A draft revision of agency policy clarifying this interpretation is now being reviewed in Central Office.

More importantly, this provision fails to address a more serious problem we have encountered: What to do when the competing health-care facility doesn't have any minimum rate but all salaries are individually negotiated. This problem exists particularly at Director grade.

The use of hiring rates is not an appropriate solution to this problem. Individually negotiated salaries, especially for positions corresponding to VA Director grade assignments, are almost always much higher than minimum rates because they reflect the special qualifications and salary history of the appointee. Therefore, VA would be using middle or even maximum rates to set minimum rates, quickly or immediately becoming the community pay leader. We will continue to review this situation, and will initiate further administrative action or legislative proposals if warranted.

Pay adjustments for transferring employees

Section 7 of the bill authorizes the Secretary to establish, for employees who transfer to another VA facility at VA's request, a higher rate than that available under the locality-based nurse pay system. We oppose this provision.

However, if enacted, we would prefer the ability to simply maintain the pay level of employees who transfer at VA request in the form of pay retention similar to that available to other Federal employees under Chapter 53, title 5, United States Code, and that it be discretionary, subject to regulations promulgated by the Secretary. Unlike pay retention, this provision would create another pay rate-setting procedure which is unnecessary, confusing, and which would result in multiple pay rate procedures at a single facility for the same occupation. Also, it does not provide any mechanism for future adjustments. Finally, the legislation does not clearly state that it would not apply to employees transferred as the result of disciplinary action.

Effective date

We note that the bill lacks an effective date. Due to the complications involved in establishing a new pay grade, including revision of the qualifications standards and survey job descriptions, issuing instructions to the field, conducting new surveys, and establishing new schedules, we recommend that the effective date for any nurse pay provisions be set as the first pay period after April 1, 1993, or the first pay period after the date which is 6 months after enactment, which ever is later.

Respite Care Program—Permanent authority

Section 8 of the bill would provide permanent legal authority for our Respite Care Program. The program, which Congress first authorized in 1986, allows our medical centers to provide chronically ill veterans who reside at home with brief, planned periods of care in the medical center. These episodes of VA care are actually intended to provide the veteran's family members with relief from the physical and emotional strains of providing the veteran with daily care. Giving the family caregivers periods of "respite" en-

ables them to continue providing care over the long term, thereby allowing veterans to continue living at home.

Since its inception, the Respite Care Program has been well received by veterans, their families, and health-care providers. There is no doubt that it has enabled veterans to delay, and in many instances, avoid the need for long term hospitalization. Respite care is a successful and cost effective alternative to long term institutionalization for many veterans with chronic illness. We support section 8.

Contracts for care—The Philippines

Section 9 of the bill would extend through December 31, 1996, the President's authority to enter into contracts with the Veterans Memorial Medical Center (VMMC) in the Philippines. These contracts provide payments for hospital and nursing home care to United States veterans in that hospital. For many years we have recognized the obligation of the United States to provide care to Filipino veterans who served in our Armed Services. That obligation continues, and the contract care authority continues to be needed to fulfill the obligation. Thus, we support extension of the authority.

We note that section 9 does not extend the Secretary's authority to make grants to the VMMC for replacing and upgrading equipment and rehabilitating the hospital's physical plant and facilities. Annual grants for those purposes have been authorized for many years, and are reflected in the President's fiscal year 1993 Budget. We recommend that you extend the grant program for five years, and authorize $500,000 annually for the grants.

Health Professional Scholarship Program—Permanent authority

Section 10 of the bill would provide permanent legal authority for our Health Professional Scholarship Program.

Since Congress first authorized the Scholarship Program in 1980, it has been a valuable tool in the recruitment and retention of registered nurses. We began providing scholarships to students in physical and occupational therapy in, respectively, 1988 and 1990, because it is also very difficult to recruit and retain employees in those two professions. Under the program, we provide carefully selected students with a scholarship consisting of tuition, a monthly stipend, and the expenses of materials such as books. We provide scholarships to students in the last one or two years of their schooling. In exchange, they agree to work for VA on completion of their degree for a one year period for each year that we provide support. The scholarship program helps ensure a continuous influx of health-care professionals into our system.

We support a four year continuation of the program. In the current rapidly changing world of health care personnel, we believe the usefulness of this program should be reevaluated in the near future. We also ask that the Committee consider amending this program by raising the minimum service obligation from one year to two years.

State Home Grant Program—Permanent authority

Section 11 would permanently authorize appropriations for the conduct of our State Home Grant Program. The program provides assistance to States in the construction, acquisition, remodeling, and renovation of State home facilities. These facilities furnish eligible veterans with hospital, domiciliary, and nursing home care. The homes are operated by the States, and represent an example of a Federal/State partnership to provide care to many of our neediest veterans. The program is cost-effective in that Federal participation is limited to no more than 65 percent of the cost of any one project. We support continuation of the program.

Preventive health care—S. 2740

I will next comment on S. 2740, your bill which is aimed at enhancing our ability to provide veterans with preventive health care services. We can all agree that many preventive medicine services are desirable and in many cases are cost-effective. Early detection and treatment of disease is best for the patient, and best for the taxpayer. We want to place a greater emphasis on preventive health care in the VA, but we don's think this bill will provide us with any additional tools to do that. Rather, it would direct us to use funds on activities which are peripheral to the primary task of providing services to veterans. We oppose enactment of the bill.

The draft bill would essentially do four things. First, it would officially repeal authority for the preventive health care pilot program that operated in VA from 1985 through 1988, but would retain the definition of the term "preventive health-care services" which was used in that pilot program. Second, the bill would direct that I, as Chief Medical Director, establish and operate a National Center for Preventive Health. Third, the bill would direct the Secretary to establish a Preventive Health Services Advisory Committee. Finally, the bill would require the Secretary to report annually to the Congress regarding VA efforts to provide preventive health services.

We oppose this bill as simply unnecessary. As I stated, we now have a comprehensive preventive health care program that operates throughout our health-care system. Each of our medical centers has a Preventive Medicine Facility coordinator, and there is a National Program Director in Central Office. That office seeks to disseminate information about preventive health-care, and coordinate the program. It also seeks to encourage research in this area. Our existing office does much of what we envision a national center doing. We also don't believe VA needs an advisory committee on preventive health care at this time. Both the Secretary and I have adequate authority to obtain the advice we need in this area, including the authority to establish an advisory committee if that becomes desirable. Finally, we will always make information available to Congress on preventive health care in the VA. We don't believe a detailed annual report on the subject, such as this bill would require, would be useful or cost-effective.

Mobile Health-Care Clinic Program—S. 1424

Mr. Chairman, I next turn to S. 1424, a bill introduced last year which would direct us to undertake a broadened program of furnishing care in rural areas through the use of mobile health care clinics. We strongly oppose enactment of the bill.

S. 1424 would add a new section to title 38 which would direct the Secretary to begin operating at least three new mobile health care clinics each year for a five-year period. The bill would require that we locate the clinics in states with large populations of veterans living in rural areas. To receive care in one of the clinics, a veteran would have to live in a state where a clinic is located, live at least 100 miles from a VA health-care facility, and be otherwise eligible for VA health-care benefits. The bill would require an evaluation of the program at the end of five years, and a report to Congress regarding the evaluation.

As you know, we have advanced quite far in our pilot program of using mobile health care clinics to care for veterans in rural areas. That effort began with enactment of Public Law 100–322, which established a program to furnish care with mobile clinics in four locations. We went through an elaborate process to select the original four sites for clinics, and subsequently, two additional sites were added. Thus, we now plan on operating six mobile clinics in six parts of the country. We awarded a contract for construction of the six clinics last Fall, and delivery is expected in September of this year. The six medical centers which will administer the clinics have been allocated funds this year to prepare for delivery of the clinics this fall, and to hire personnel to staff the clinics.

We believe mobile clinics should be tested at the six sites before adding additional clinics. We want to determine whether mobile clinics are the best and most cost-effective mechanism to furnish such care in rural areas. The clinics are relatively expensive, and it remains to be seen whether they will be able to meet the health-care needs of veterans beyond serving as a location for referral to facilities that can provide a higher level of service. We need to operate the six planned clinics for a period of time before we will be able to say whether the costs and benefits of mobile clinics are justified. We strongly believe that large scale expansion of the program, as this bill proposes, is not at all warranted at this time.

Oversight issues

Mr. Chairman, you also requested that we address the General Accounting Office's April 1992 report on its review of four VA psychiatric hospitals. I have provided a detailed response to questions you raised in your April 30 letter to Secretary Derwinski that I believe fully addresses issues raised by GAO's review. I ask that this response be made part of the hearing record.

The GAO review of four VA hospitals and six non-VA hospitals found that VA and private psychiatric hospitals have similar review mechanisms in place that generally meet JCAHO accreditation standards. GAO's review was based on fiscal year 1988–90 VA data, which does not reflect any of the quality management improvements that have been undertaken since August 1990. We have made significant progress in improving quality management

in VHA and have a number of special evaluation efforts underway that will fully respond to the problems identified by the GAO review.

Mr. Chairman, on March 31, 1993, VA submitted a report as required by Public Law 102–25 on its clinical and assessment efforts to assist veterans of Operation Desert Storm. This report was based on clinical experiences and research undertaken by VA during the past year.

Formal assessment data collected on over 4,500 Persian Gulf veterans suggests the following:

Approximately 9 percent of Persian Gulf returnees had symptoms scoring in the PTSD range.

As many as 34 percent appear to have experienced other forms of significant psychological distress during the months after their return from the Middle East.

As expected, troops who were most exposed to war zone stressors report the highest symptom levels, and troops deployed to the Middle East have higher symptom levels than those not so deployed. These findings suggest the existence of a specific relationship between service in the Persian Gulf War and psychological distress.

There is some evidence that stressful pre-deployment experiences and post-deployment family adjustment problems are also associated with more severe symptomatology.

While informative, it must be noted that these data were collected in selected locations shortly after troops returned from overseas and, therefore, is not a scientific probability sample of all Persian Gulf troops.

Both VA Medical Centers and Vet Centers have initiated efforts to provide special outreach and other clinical services to Persian Gulf veterans and have been provided additional funds to expand the services they provide. As of April 1992, VA Medical Centers had provided services to over 60,000 Persian Gulf veterans while VA Readjustment Counseling Service Vet Centers offered assistance to over 23,000 veterans. During the coming years, VA professionals across the country will be carefully assessing Persian Gulf veterans for indications of PTSD as well as any other manifestations of war zone stress. In view of the importance of identifying the delayed emergence of adjustment problems, the National Center for PTSD and others will continue their longitudinal research efforts.

Mr. Chairman, this completes my testimony. I would be pleased to respond to any questions.

DEPARTMENT OF VETERANS AFFAIRS,
June 23, 1992.

Hon. ALAN CRANSTON,
Chairman, Committee on Veterans Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: This will respond to your request for a report on S. 2715, 102nd Congress, 2nd Session, a bill "[t]o require the Secretary of Veterans Affairs to carry out demonstration projects to determine the feasibility and desirability of installing

telephones in Department of Veterans Affairs health-care facilities for use by patients of such facilities."

S. 2715 would require the Secretary to carry out demonstration projects at the Philadelphia and Tucson VA Medical Centers (VAMC) to evaluate the feasibility and desirability of installing telephones for patient use at VA health-care facilities. The phones would be installed in patients' rooms and the patients would be financially responsible for long distance calls.

S. 2715 would require the evaluation of the Philadelphia and Tucson projects to include the cost of installation, maintenance and use of the telephones as well as any costs incurred in providing special telephones or equipment necessary to enable disabled veterans to use the phones. The bill would also require inclusion of the amount of any savings resulting from the demonstration projects, such as a decrease in the amount of assistance in using telephones that VAMC staff would otherwise provide to patients. Lastly, the Secretary would be required to evaluate the therapeutic impact of the demonstration projects.

Finally, S. 2715 would require the Secretary to submit a report to the Congress containing: the aforementioned determinations necessary for his evaluation of the projects; his assessment of the feasibility and desirability of providing patient telephones throughout the system; and any additional information or recommendations concerning the furnishing of telephones for patients which he considers appropriate.

The Department supports the concept of patient bedside telephones, but we strongly oppose enactment of S. 2715. In 1985 our Office of the General Counsel opined that it is within the discretion of the Chief Medical Director (CMD) to determine that the provision of bedside phone service is necessary for a complete medical and hospital service under 38 U.S.C. § 7301 (formerly section 4101). Since that time several VAMCs have obtained bedside phone service for some or all of their patients through donations from outside organizations. these VAMCs are Boise, Idaho; Bronx, New York; Castle Point, New York; Hines Illinois; Miami, Florida; and San Diego, California. Hence, VA has no need for additional statutory authority concerning the provision of patient phones inasmuch as the Department already has the requisite authority to furnish such service. Likewise, the Department has no need to carry out the demonstration projects described in the bill in light of the fact that at least six facilities presently furnish bedside phone service to patients.

Moreover, VA has already made the determination required by S. 2715 as to the feasibility and desirability of providing phone service in patients' rooms, and has developed a budget initiative to implement same. At the request of Senator Frank Murkowski the General Accounting Office (GAO) identified ways that VAMCs could reduce the amount of time that VA nurses spend on nonclinical activities. One of the recommendations which resulted from this GAO review was that the Department develop and implement a plan to place telephone service in patients rooms. See "VA HEALTHCARE Telephone Service Should Be More Accessible to Patients" GAO/HRD-91-110 (attached).

On October 2, 1991, in response to this report, I informed Senator Murkowski that I agreed with the GAO conclusion to place telephones in VA patients' rooms and that Veterans Health Administration (VHA) was developing a plan to do so. VHA has since drafted a budget initiative to fund the installation of such phone service commencing in FY 1994 and continuing for 5 fiscal years. The initiative will be considered during the formulation of the Department's 1994 budget along with other program enhancements. Therefore, the demonstration projects would not serve their stated purpose, to assist me in deciding whether bedside phones should be available throughout the system, as this determination has already been made.

Additionally, S. 2715 would interfere with the Department's ability to most efficiently allocate its resources. We estimate that implementation of the bill will cost VA $1.9 million in FY 1993. As discussed, several of the current bedside phone systems have been obtained with donated funds. However, we have no guarantees that sufficient donations could be obtained for the Philadelphia and Tucson projects. Further, all of the funds available for patient phones in VA's telephone equipment account have been designated for other projects. Hence, if the Department does not receive donations sufficient to cover the Philadelphia and Tucson projects then VA would have to use monies already designated for bedside phone service at other VAMCs. Additionally, if the Philadelphia and Tucson phone systems had to be fully funded from the telephone equipment account, then as many as 10 to 15 other such projects would be adversely impacted by the diversion of funds due to the high installation costs at those two facilities.

Installation at these two facilities would cost $2,000 per telephone, because neither their telephone switches nor wiring can support the additional service. This cost estimate assumes that the bedside phones will be installed concurrent with a normally scheduled switch replacement, which involves upgrading a facility's entire phone system. Thus, the $2,000 per telephone figure is derived by dividing the total installation cost by the number of phones at a facility, usually several thousand.

However, if VA were to install only patient phones at a given VAMC, then the per unit cost could increase by several fold as the total amount for installation would be divided by several hundred, not several thousand phones. Hence, compelling the Department to install bedside phones at Philadelphia and Tucson prior to the scheduled switch replacement would cause VA's per unit costs to increase drastically. In contrast, installation at a facility where the current switch and wiring can support the additional phones would be $250.00 per telephone.

If the Department waited until the scheduled switch replacements at these VAMCs to commence installation, then it would be impossible to complete the demonstration projects within the time limits of S. 2715. Consequently, the bill would require the Department to pursue to costlier route of installation prior to the scheduled switch replacement.

We include the following cost estimate for enacting S. 2715.

[In million of dollars]

Fiscal years:	*Amount*
1993	1.900
1994	2.110
1995	2.221
1996	2.332
1992	2.442
1988	2.554

The Office of Management and Budget advises that there is no objection from the standpoint of the Administration's program to the submission of this report on S. 2715 to the Congress.

Sincerely yours,

EDWARD J. DERWINSKI.

Enclosures.

CHANGES IN EXISTING LAW MADE BY S. 2575 AS REPORTED

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 10—UNITED STATES CODE

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Subtitle A—General Military Law

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PART II—PERSONNEL

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CHAPTER 55—MEDICAL AND DENTAL CARE

Sec.
1071. Purpose of this chapter.

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1107. Procurement of drugs and biologicals through depots.

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§ 1107. Procurement of drugs and biologicals through depots

(a) IN GENERAL.—(1) The Secretary of Defense may enter into agreements with manufacturers referred to in paragraph (2) under which agreements the Secretary of Defense and such manufacturers shall determine the price of drugs and biologicals manufactured by such manufacturers and available for purchase through depots of the Department of Defense.

(2) The manufacturers referred to in paragraph (1) are any manufacturers of drugs or biologicals that have entered into an agreement with the Administrator of the General Services Administra-

tion with respect to such drugs or biologicals under section 1001 of the Federal Property and Administrative Services Act of 1949.

(b) PROCUREMENT OF DRUGS AND BIOLOGICALS.—The Secretary of Defense may procure for any facility of the uniformed services any drug or biological that is subject to an agreement under this section.

(c) PRICES.—(1) Subject to subsection (d), the price under an agreement under this section of a covered drug or biological that was the subject of a contract for procurement by the Department of Defense through a depot on September 1, 1990, shall be as follows:

(A) During the 1-year period beginning on the effective date of the agreement, the price shall be an amount no greater than .76 multiplied by an amount equal to—

(i) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(A)) is positive—

(I) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary of Defense by the manufacturer), minus

(II) the additional price discount amount (as determined under subsection (h)(1)(A)); or

(ii) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(A)) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based).

(B) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period increased by the same percentage as the increase in the price index during the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

(2) Subject to subsection (d), the price under an agreement under this section of a covered drug or biological that was not the subject of a contract referred to in paragraph (1) on September 1, 1990, but was approved by the Administrator of the Food and Drug Administration on or before the date of the enactment of this Act, shall be as follows:

(A) During the 1-year period beginning on the effective date of the agreement—

(i) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

(I) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(A)) is positive—

(aa) the Federal average manufacturer price of the drug or biological for the most recent 12-month

period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary of Defense by the manufacturer), minus

(bb) the additional price discount amount (as determined under subsection (h)(1)(A)); or

(II) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(A)) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based); or

(ii) in the case of a drug or biological for which such data does not permit the calculation of Federal average manufacturer price for as many months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

(I) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(B)) is positive—

(aa) the Federal average manufacturer price of the drug or biological for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before the effective date of the agreement for which price data are available (as so based), minus

(bb) the additional price discount amount (as determined under subsection (h)(1)(B)); or

(II) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(B)) is not positive, the Federal average manufacturer price of the drug or biological for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before the effective date of the agreement for which price data are available (as so based).

(B) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during such the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

(3) Subject to subsection (d), the price under an agreement under this section of a covered drug or biological that is approved by the Administrator of the Food and Drug Administration after the date of the enactment of this Act, shall be as follows:

(A) During the 1-year period beginning on the effective date of the agreement—

(i) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

(I) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)A)) is positive—

(aa) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary of Defense by the manufacturer), minus

(bb) the additional price discount amount (as determined under subsection (h)(1)(A)); or

(II) in the case of a drug or biological whose Federal average price differential (as determined under subsection (h)(6)(A)) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based); or

(ii) in the case of a drug or biological for which such data does not permit the calculation of Federal average manufacturer price for as many months, the price shall be an amount no greater than .76 multiplied by an amount equal to the Federal average manufacturer price of the drug or biological (as so based) for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before such effective date for which such data are available.

(B) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during such the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

(4) Subject to subsection (d), the price under an agreement under this section of a covered drug or biological whose price was determined under paragraph (1), (2), or (3), or under this paragraph, pursuant to an agreement that is expiring, shall be as follows:

(A) During the 1-year period beginning on the effective date of the agreement, the price may not exceed the price of the drug or biological under the expiring agreement during the 1-year period beginning on the effective date of the expiring agreement increased by the same percentage as the increase in the price index during the period beginning on the effective date of the expiring agreement and ending on the last day of the last month before the effective date of the agreement under this subsection for which price index data are available.

(B) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

(5) The price under an agreement under this section of a drug or biological (other than a covered drug or biological) shall be jointly determined by the Secretary of Defense and the manufacturer of the drug or biological.

(d) EXCESS PRICE.—(1) In entering into an agreement under paragraphs (1), (2), (3), or (4) of subsection (c) for the depot price of a drug or biological, the Secretary of Defense may provide for a price of a drug or biological during the 1-year period beginning on the effective date of the agreement that is nominally in excess (as determined by that Secretary) of the price that would be determined for the drug or biological during that period under that paragraph if that Secretary determines that such excess price is in the best interests of the Department of Defense.

(2) If the Secretary of Defense exercises the authority under this subsection to establish an excess price with respect to the price of a drug or biological during a 1-year period, the determination of the amount of the increase in the price of the drug or biological for the succeeding 1-year period, if any, shall be based on such excess price.

(e) ENTRY INTO AGREEMENTS.—(1) Except as provided in paragraph (2), the Secretary of Defense shall enter into agreements with manufacturers under this section not later than the later of—

(A) 6 months after the date of the enactment of this section; or

(B) 30 days after that Secretary notifies the manufacturers of that Secretary's intention to enter into such agreements.

(2) In the case of a drug or biological that is first marketed after the date that is 5 months after the date of the enactment of this section, the Secretary of Defense shall enter into an agreement referred to in paragraph (1) not later than the later of—

(A) 3 months after the date such marketing begins; or

(B) 30 days after that Secretary notifies the manufacturer of that Secretary's intention to enter into such an agreement.

(f) TERM OF AGREEMENT.—The Secretary of Defense shall determine the term of any agreement entered into by that Secretary and a manufacturer under this section.

(g) REPORTS ON PRICES.—(1)(A) The manufacturer of a covered drug or biological whose price is determined by an agreement under this section shall report to the Secretary of Defense the Federal average manufacturers price of the drug or biological during each calendar quarter in which the agreement is in force. The manufacturer shall report such price not more than 30 days after the expiration of a covered quarter.

(B) The report required under subparagraph (A) shall be in addition to the reports required under clauses (i)(I) and (ii) of subsection (c)(1)(A), subclauses (I)(aa) and (II) of subsection (c)(2)(A)(i), subclauses (I)(aa) and (II) of subsection (c)(3)(A)(i), and subsection

(c)(3)(A)(ii). The reports required under such subparagraphs shall be submitted upon the request of the Secretary of Defense.

(2) The Secretary of Defense may impose a civil monetary penalty in an amount equal to $10,000 on any manufacturer that fails to report the information required under paragraph (1) on a timely basis. Such amount shall be paid to the Treasury. The amount of the penalty shall be increased by $10,000 for each day in which such information has not been reported, and such amount shall be paid to the Treasury. If such information with respect to a drug or biological is not reported within 90 days of the deadline imposed, the Secretary of Defense may prohibit the purchase of the drug or biological through the supply schedule or Department depots after the end of such 90-day period and until the date such information is reported but in no case shall such prohibition be for a period of less than 30 days.

(3) Any manufacturer that knowingly reports false information to the Secretary of Defense under subparagraph (A) of paragraph (1) or the provisions of law referred to in subparagraph (B) of such paragraph is subject to a civil monetary penalty in an amount not to exceed $100,000 for each item of false information reported. Such amount shall be paid to the Treasury.

(4) The civil money penalties described in paragraphs (2) and (3) are in addition to other penalties as may be prescribed by law.

(5) In order to determine the accuracy of the price of a covered drug or biological that is reported to the Secretary of Defense under the provisions of law referred to in paragraph (3), the Secretary of Defense may audit—

(A) the relevant records of any manufacturer of a covered drug or biological that is the subject of an agreement under this section; and

(B) the relevant records of any wholesaler that distributes such a drug or biological.

(6) All information contained in a report submitted to the Secretary of Defense under this section by a manufacturer shall remain confidential.

(h) DEFINITIONS.—In this section:

(1) The term "additional price discount amount", in the case of the price of a drug or biological whose price is established under an agreement under this subchapter, means—

(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at lease 15 months, the amount of the difference, if any, between—

(i) the Federal average price differential (or determined under paragraph (6)(A)); and

(ii) the amount equal to—

(I) the Federal average manufacturer price of the drug or biological for the 3-month period ending on the date that is 12 months before the last day of the last month before the effective date of the agreement for which price index data and price data for the drug or biological are available, multiplied by

(II) the percentage increase in the price index during that 12-month period; or

(B) in the case of a drug or biological for which such data does not permit the calculation of that price for as many months, the amount of the difference, if any, between—

(i) the Federal average price differential (as determined under paragraph (6)(B)); and

(ii) an amount equal to—

(I) the Federal average manufacturer price of the drug or biological for the 3-month period beginning on the first day of the month next following the month in which marketing of the drug or biological begins, multiplied by

(II) the percentage increase in the price index during the period beginning on such day and ending on the last day of the last month before the effective date of the agreement for which price index data are available.

(2) The term "covered drug or biological" means—

(A) any drug marketed under a new drug application approved by the Secretary Health and Human Services under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(B) any biological marketed under a product licensing application approved by the Administrator of the Food and Drug Administration pursuant to section 351 of the Public Health Service Act (42 U.S.C. 262).

(3) The term "depot" means a centralized commodity management system operated by the Department of Defense through which drugs and biologicals procured for the use of entities of the Department of Defense are—

(A) received, stored, and delivered through—

(i) a warehouse system under the jurisdiction and operation of the Department of Defense; or

(ii) a commercial entity operating under contract with the Department of Defense; or

(B) delivered directly from the manufacturer to the entity using the drugs or biologicals.

(4) The term "depot price" means the price of a drug or biological under an agreement between the Secretary of Defense and the manufacturer of the drug or biological to determine the price of the drug or biological for purchase through depots.

(5) The term "Federal average manufacturer price", with respect to a covered drug or biological and a specified period of time, means the weighted average price of a single form and dose unit of the drug or biological that is paid to the manufacturer of the drug or biological, taking into account any cash discounts or similar price reductions, during that period by wholesalers (other than a price paid by the Federal Government).

(6) The term "Federal average price differential", with respect to a covered drug or biological whose price is established under an agreement under this subchapter, means—

(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months—

(i) the Federal average manufacturer price of the drug or biological during the 3-month period ending on the last day of the last month before the effective date of the agreement for which price data and price index data are available, minus

(ii) the Federal average manufacturer price of the drug biological during the 3-month period ending on the date that is 1 year before the ending of such 3-month period; or

(B) in the case of a drug or biological for which such data does not permit the calculation of that price for as many months—

(i) the Federal average manufacturer price of the drug or biological during the 3-month period ending on the last day of the last month before effective date of the agreement for which price data and price index data are available, minus

(ii) the Federal average manufacturer price of the drug or biological during the 3-month period beginning on the first day of the first month next following the month in which market of the drug or biological begins.

(7) The term "manufacturer", with respect to a drug or biological, means—

(A) an entity that both manufacturers and distributes the drug or biological; or

(B) if no such entity exists, an entity that distributes the drug or biological.

the Term does not include a wholesale distributor or drugs or biologicals, a retail pharmacy licensed under State law, or a practitioner licensed under State law and authorized to dispense drugs and bilogicals.

(8) The term "price index" means the Producer Price Index—Finished Goods published monthly by the Bureau of Labor Statistics.

(9) The term "weighted average price", with respect to a covered drug or biological and a specified period of time means—

(A) the sum of the products of—

(i) the average price per unit of each package quantity of the drug or biological sold during the period, and

(ii) the number of units of the drug or biological sold at the average price, divided by

(B) the total number of units of the drug or biological sold during the period.

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TITLE 38—UNITED STATES CODE

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PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

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[SUBCHAPTER VII—PREVENTIVE HEALTH-CARE SERVICES PILOT PROGRAM

SUBCHAPTER I—GENERAL

§ 1701. Definitions

For the purposes of this chapter—
(1) * * *

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(6) The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative services—

(A)(i) surgical services, dental services and appliances as described in sections 1710 and 1712 of this title, optometric and podiatric services (in the case of a person otherwise receiving care or services under this chapter), preventive [health-care services as defined in section 1762 of this title,] *health services,* and (except under the conditions described in section 1712(a)(5)(A) of this title), wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or

services as the Secretary determines to be reasonable and necessary, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and

(B)(i) such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment—

(I) of the service-connected disability of a veteran pursuant to section 1712(a) of this title, and

(II) in the discretion of the Secretary, of the non-service-connected disability of a veteran eligible for treatment under section 1712(a)(5)(B) of this title where such services were initiated during the veteran's hospitalization and the provision of such services on an outpatient basis is essential to permit the discharge of the veteran from the hospital,

for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, travel and incidental expenses of such family member or individual in the case of a veteran who is receiving care for a service-connected disability, or in the case of a dependent or survivor of a veteran receiving care under the last sentence of section 1713(b) of this title); and

(ii) in the case of an individual who was a recipient of services under subclause (i) of this clause at the time of—

(I) the unexpected death of the veteran; or

(II) the death of the veteran while the veteran was participating in a hospice program (or a similar program) conducted by the Secretary,

such counseling services, for a limited period, as the Secretary determines to be reasonable and necessary to assist such individual with the emotional and psychological stress accompanying the veteran's death.

For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under the last sentence of section 1713(b) of this title shall be eligible for the same medical services as a veteran.

* * * * * * *

(A) periodic medical and dental examinations (including screening for high blood pressure, glaucoma, high cholesterol, and colorectal and gender-specific cancers);

(B) patient health education (including education relating to nutrition, stress management, physical fitness, and stopping smoking);

(C) maintenance of drug use profiles, patient drug monitoring, and drug utilization education;

(D) mental health preventive services;

(E) substance abuse preventive measures;

(F) immunizations against infections disease;

(G) prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature;

(H) genetic counseling concerning inheritance of genetically determined diseases;

(I) routine vision testing and eye care services;

(J) periodic reexamination of members of likely target populations (high-risk groups) for selected diseases and for functional decline of sensory organs, together with attendant appropriate remedial intervention; and

(K) such other health-care services as the Secretary may determine to be necessary to provide effective and economical preventive health care.

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SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

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§ 1718. Therapeutic and rehabilitative activities

(a) * * *

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(G)(1) Neither a veteran's participation in a program of rehabilitative services that is provided as part of the veteran's care furnished by a State home and is approved by the Secretary as conforming appropriately to standards for activities carried out under this section nor a veteran's receipt of payment as a result of such participation may be considered as a basis for the denial or discontinuance of a rating of total disability for purposes of compensation or pension based on the veteran's inability to secure or follow a substantially gainful occupation as a result of disability.

(2) A payment made to a veteran under a program of rehabilitative services described in paragraph (1) shall be considered for the purposes of chapter 15 of this title to be a donation from a public or private relief or welfare organization.

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§ 1720B. Respite care

(a) * * *

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[(c) The authority provided by this section terminates on September 30, 1992.]

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§ 1720D. Health care through rural clinics

(a) During the three-year period beginning on October 1, 1992, the Secretary shall conduct a rural health-care clinic program in States where significant numbers of veterans reside in areas geographically remote from existing health-care facilities (as determined by the Secretary). The Secretary shall conduct the program in accordance with this section.

(b)(1) In carrying out the rural health-care clinic program, the Secretary shall furnish medical services to the veterans described in subsection (c) through use of—

(A) mobile health-care clinics equipped, operated, and maintained by personnel of the Department; and

(B) other types of rural clinics, including part-time stationary clinics for which the Secretary contracts and part-time stationary clinics operated by personnel of the Department.

(2) The Secretary shall furnish services under the rural health-care clinic program in areas—

(A) that are more than 100 miles from a Department general health-care facility; and

(B) that are less than 100 miles from such a facility, if the Secretary determines that the furnishing of such services in such areas is appropriate.

(c) A veteran eligible to receive medical services through rural health-care clinics under the program is any veteran eligible for medical services under section 1712 of this title.

(d) The Secretary shall commence operation of at least three rural health-care clinics (at least one of which shall be a mobile health-care clinic) in each fiscal year of the program. The Secretary may not operate more than one mobile health-care clinic under the authority of this section in any State in any such fiscal year.

(e) Not later than December 31, 1996, the Secretary shall submit to Congress a report containing an evaluation of the program. The report shall include the following:

(1) A description of the program, including information with respect to—

(A) the number and type of rural health-care clinics operated under the program;

(B) the States in which such clinics were operated;

(C) the medical services furnished under the program, including a detailed specification of the cost of such services;

(D) the veterans who were furnished services under the program, setting forth (i) the numbers and percentages of the veterans who had service-connected disabilities, (ii) of the veterans having such disabilities, the numbers and percentages who were furnished care for such disabilities, (iii) the ages of the veterans, (iv) taking into account the veterans' past use of Department health-care facilities, an analysis of the extent to which the veterans would have received medical services from the Department outside the program and the types of services they would have received, and (v) the financial circumstances of the veterans; and

(E) the types of personnel who furnished services to veterans under the program, including any difficulties in the recruitment or retention of such personnel.

(2) An assessment by the Secretary of the cost-effectiveness and efficiency of furnishing medical services to veterans through various types of rural clinics (including mobile health-care clinics operated under the pilot program conducted pursuant to section 113 of the Veterans' Benefits and Services Act of 1988 (Public Law 100–322; 38 U.S.C. 1712 note)).

(3) Any plans for administration action, and any recommendations for legislation, that the Secretary considers appropriate.

(f) For the purposes of this section, the term "Department general health-care facility" has the meaning given such term in section 1712A(i)(2) of this title.

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SUBCHAPTER IV—HOSPITAL CARE AND MEDICAL TREATMENT FOR VETERANS IN THE REPUBLIC OF THE PHILIPPINES

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§ 1732. Contracts and grants to provide for the care and treatment of United States veterans by the Veterans Memorial Medical Center

(a) The President, with the concurrence of the Republic of the Philippines, may authorize the Secretary to enter into contracts with the Veterans Memorial Medical Center, with the approval of the appropriate department of the Government of the Republic of the Philippines, covering the period beginning on October 1, 1981, and ending on [September 30, 1992,] *December 31, 1996,* under which the United States—

(1) will provide for payments for hospital care and medical services (including nursing home care) in the Veterans Memorial Medical Center, as authorized by section 1724 of this title and on the terms and conditions set forth in such section, to eligible United States veterans at a per diem rate to be jointly determined for each fiscal year by the two Governments to be fair and reasonable; and

(2) may provide that payments for such hospital care and medical services provided to eligible United States veterans may consist in whole or in part of available medicines, medical supplies, and equipment furnished by the Secretary to the Veterans Memorial Medical Center at valuations therefor as determined by the Secretary, who may furnish such medicines, medical supplies, and equipment through the revolving supply fund pursuant to section 8121 of this title.

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SUBCHAPTER V—PAYMENTS TO STATE HOMES

§ 1741. Criteria for payment

(a) * * *

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(e) Subject to section 1743, the payment of per diem for care furnished in a State home facility shall commence on the date of the completion of the inspection for recognition of the facility under section 1742(a) of this title if the Secretary determines, as a result of that inspection, that the State home meets the standards described in such section 1742(a).

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[SUBCHAPTER VII—PREVENTIVE HEALTH-CARE SERVICES PILOT PROGRAM

[§ 1761. Purpose

[The purpose of this subchapter is to provide for a preventive health-care services pilot program in order to help (1) ensure the best possible health care for certain veterans otherwise being furnished care or services under this chapter, including veterans with service-connected disabilities rated at 50 per centum or more and veterans being furnished care or services involving a service-connected disability under this chapter, by furnishing to such veterans feasible and appropriate preventive health-care services, and (2) determine the cost effectiveness and medical advantages of furnishing such preventive health-care services.

[§ 1762. Definition

[For the purposes of this subchapter, the term "preventive health-care services" means—

[(1) periodic medical and dental examinations;

[(2) patient health education (including nutrition education);

[(3) maintenance of drug use profiles, patient drug monitoring, and drug utilization education;

[(4) mental health preventive services;

[(5) substance abuse preventive measures;

[(6) immunizations against infectious disease;

[(7) prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature;

[(8) genetic counseling concerning inheritance of genetically determined diseases;

[(9) routine vision testing and eye care services;

[(10) periodic reexamination of members of likely target populations (high-risk groups) for selected diseases and for functional decline of sensory organs, together with attendant appropriate remedial intervention; and

[(11) such other health-care services as the Secretary may determine to be necessary to provide effective and economical preventive health care.

[§ 1763. Preventive health-care services

[(a)(1) In order to carry out the purpose of this subchapter, the Secretary, within the limits of Department facilities and in accordance with regulations which the Secretary shall prescribe, shall, during fiscal years 1984 through 1988, furnish to any veteran described in section 1712(a)(1)(B) of this title otherwise being furnished care or services under this chapter, and to any veteran receiving care or services under this chapter involving a service-connected disability, such preventive health-care services as the Secretary determines are feasible and appropriate. In carrying out the pilot program under this subchapter, the Secretary may furnish such preventive health-care services to any other veteran described in section 1712(a)(1)(B) of this title.

[(2) In connection with preventive health-care services furnished under paragraph (1) of this subsection, the Secretary, in accordance

with regulations which the Secretary shall prescribe, may institute appropriate controls and carry out followup studies (including research) to determine the medical advantages and cost effectiveness of furnishing such preventive health-care services.

[(b) In carrying out this subchapter, the Secretary shall emphasize the utilization of interdisciplinary health-care teams composed of various professional and paraprofessional personnel.

[(c) In carrying out the program provided for in this subchapter, the Secretary may not expend more than $10,000,000 in fiscal year 1980, more than $12,000,000 in fiscal year 1981, more than $13,000,000 in fiscal year 1982, more than $14,000,000 in fiscal year 1983, or more than $15,000,000 in each of fiscal years 1984 through 1988.

[§ 1764. Reports

[The Secretary shall include in the annual report to the Congress for each of fiscal years 1984 through 1988 required by section 529 of this title a comprehensive report on the administration of this subchapter, including such recommendations for additional legislation as the Secretary considers necessary.]

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PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

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CHAPTER 73—VETERANS HEALTH ADMINISTRATION—ORGANIZATION AND FUNCTIONS

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SUBCHAPTER II—GENERAL AUTHORITY AND ADMINISTRATION

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SUBCHAPTER I—ORGANIZATION

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§ 7306. Office of the Chief Medical Director

(a) The Office of the Chief Medical Director shall consist of the following:

(1) * * *

* * * * * * *

(7) The Director of the National Center for Preventive Health, who shall be responsible to the Chief Medical Director for the operation of the Center.

[(7)] *(8)* Such other personnel as may be authorized by this chapter.

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(c) Appointments under subsection (a) shall be made by the Secretary. In the case of appointments under paragraphs (1), (2), (3), *(4),* and [(4)] *(7)* of that subsection, such appointments shall be made upon the recommendation of the Chief Medical Director.

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SUBCHAPTER II—GENERAL AUTHORITY AND ADMINISTRATION

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§ 7318. National Center for Preventive Health

(a)(1) The Chief Medical Director shall establish and operate in the Veterans Health Administration a National Center for Preventive Health (hereafter in this section referred to as the "Center").

(2) The head of the Center is the Director of Preventive Health (hereafter in this section referred to as the "Director").

(3) The Chief Medical Director shall provide the Center with such staff and other support as may be necessary for the Center to carry out effectively its functions under this section.

(b) The purposes of the Center are as follows:

(1) To provide a central office for monitoring and encouraging the activities of the Veterans Health Administration with respect to the provision, evaluation, and improvement of preventive health services.

(2) To promote the expansion and improvement of clinical, research, and educational activities of the Veterans Health Administration with respect to such services.

(c) In carrying out the purposes of the Center under this section, the Director shall—

(1) develop and maintain current information on clinical activities of the Veterans Health Administration relating to preventive health services, including activities relating to—

(A) the on-going provision of regularly-furnished services; and

(B) patient education and screening programs carried out throughout the Administration;

(2) develop and maintain detailed current information on research activities of the Veterans Health Administration relating to preventive health services;

(3) in order to encourage the effective provision of preventive health services by Veterans Health Administration personnel—

(A) ensure the dissemination to such personnel of any appropriate information on such services that is derived from research carried out by the Administration; and

(B) acquire and ensure the dissemination to such personnel of any appropriate information on research and clinical

practices relating to such services that are carried out by researchers, clinicians, and educators who are not affiliated with the Administration;

(4) encourage and monitor the implementation within the Veterans Health Administration of the recommendations on preventive health services of the Advisory Committee on Preventative Health Services established under section 7319 of this title;

(5) ensure transmission to the Advisory Committee of inquiries of the Secretary or the Chief Medical Director, and the responses of the Advisory Committee to such inquiries;

(6) facilitate the optimal use of the unique resources of the Department of cooperative research into health outcomes by initiating recommendations, and responding to requests of the Chief Medical Director and the Director of the Medical and Prosthetic Research Service, for such research into preventive health services; and

(7) provide advisory services to personnel of Department health-care facilities with respect to the planning or furnishing of preventive health services by such personnel.

(d) In this section, the term "preventive health services" has the meaning given such term in section 1701(9) of this title.

§ 7319. Preventive Health Services Advisory Committee

(a) The Secretary shall establish a Preventive Health Services Advisory Committee (hereafter in this section referred to as the "Committee").

(b)(1) The membership of the Committee shall be appointed by the Secretary, upon the recommendation of the Chief Medical Director, from individuals who are not employees of the Department, and shall include individuals who are not employees of the Federal Government and who have demonstrated interest and expertise in research, education, and clinical activities related to the provision of preventive health services, and at least one representative of veterans who receive health-care services from the Veterans Health Administration.

(2) The Secretary, upon the recommendation of the Chief Medical Director, shall invite appropriate representatives of other departments and agencies of the Federal Government to participate in the activities of the Committee.

(3) The Secretary shall provide the Committee with such staff and other support as may be necessary for the Committee to carry out effectively its functions under this section.

(c)(1) The Committee shall—

(A) identify for the Secretary—

(i) the types of preventive health services that are appropriate for particular groups of veterans; and

(ii) the areas of inquiry within the field of such services that the Committee determines to be suitable for the pursuit of new or additional clinical research by the Department;

(B) make recommendations to the Secretary on—

(i) various means of initiating, enhancing, modifying, or discontinuing the provision of preventive health services by

the Department in order to ensure that such groups of veterans are provided with appropriate preventive health services; and

(ii) various means of ensuring the continued provision of preventive health services by the Department;

(C) advise the Secretary on general developments in the fields of research and clinical activities related to preventive health services; and

(D) respond to requests of the Secretary or the Chief Medical Director for information on specific research and clinical activities and ethical matters related to such activities.

(2) The Committee shall transmit any identifications, recommendations, and advice to the Secretary under subparagraphs (A), (B), and (C) of paragraph (1) through the Chief Medical Director.

(d)(1) Not later than August 1, 1993, and on an annual basis thereafter, the Committee shall submit to the Secretary a report on the activities of the Committee with respect to the matters referred to in subsection (c)(1) during the 12-month period preceding the date of the report.

(2) The Committee shall submit to the Secretary, through the Chief Medical Director, such reports in addition to the reports referred to in paragraph (1) as the Committee considers appropriate with respect to the matters referred to in subsection (c)(1). Not later than 90 days after receipt of a report under this paragraph, the Secretary shall transmit the report, together with the Secretary's comments and recommendations thereon, to the appropriate committees of the Congress.

(e) In this section, the term "preventive health services" has the meaning given such term in section 1701(9) of this title.

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CHAPTER 74—VETERANS HEALTH ADMINISTRATION—PERSONNEL

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SUBCHAPTER I—APPOINTMENTS

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§ 7404. Grades and pay scales

(a) * * *

(b)(1) The grades for positions provided for in paragraph (1) of section 7401 of this title shall be as follows. The annual ranges of rates of basic pay for those grades shall be prescribed from time to time by Executive order as authorized by chapter 53 of title 5 or as otherwise authorized by law:

PHYSICIAN AND DENTIST SCHEDULE

Director grade.
Executive grade.
Chief grade.
Senior grade.
Intermediate grade.

Full grade.
Associate grade.

NURSE SCHEDULE

[Director grade.
[Senior grade.
[Intermediate grade.
[Entry grade.]
Nurse V.
Nurse IV.
Nurse III.
Nurse II.
Nurse I.

CLINICAL PODIATRIST AND OPTOMETRIST SCHEDULE

Chief grade.
Senior grade.
Intermediate grade.
Full grade.
Associate grade.

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SUBCHAPTER II—COLLECTIVE BARGAINING AND PERSONNEL ADMINISTRATION

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§ 7426. Retirement rights

(a) * * *

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(c) The Secretary may authorize an exception to the restrictions in subsections (a), (b), and (c) of section 5532 of title 5 if necessary to meet special or emergency employment needs which result from a severe shortage of well-qualified candidates in physician positions, and registered nurse positions, which otherwise cannot be readily met. [The authority of the Secretary under the preceding sentence with respect to registered-nurse positions expires on September 30, 1992.]

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SUBCHAPTER IV—PAY FOR NURSES AND OTHER HEALTH-CARE PERSONNEL

§ 7451. Nurses and other health-care personnel: competitive pay

(a)(1) * * *

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[(3) The] *(3)(A) Except as provided in subparagraph (B), the* rates of basic pay for covered positions in the Department shall be established and adjusted in accordance with this section instead of subsection (b)(1) of section 7404 of this title or chapter 53 of title 5.

(B) Under such regulations as the Secretary shall prescribe, the Secretary shall establish and adjust the rates of basic pay for cov-

ered positions at the following health-care facilities in order to provide rates that enable the Secretary to recruit and retain sufficient numbers of health-care personnel in such positions at such facilities:

(i) The Veterans Memorial Medical Center in the Republic of the Philippines.

(ii) Department of Veterans Affairs health-care facilities located outside the contiguous States, Alaska, and Hawaii.

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(b) The Secretary shall maintain the [four] *five* grade levels for nurses employed by the Department under section 7401(a) of this title as specified in the Nurse Schedule in section 7404(b) of this title. The Secretary shall, pursuant to regulations prescribed to carry out this subchapter, establish grades for other covered positions as the Secretary considers appropriate.

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(d)(1) * * *

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(3)(A) * * *

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(C) In the event that the director of a Department health-care facility who conducts a survey of beginning rates of compensation for corresponding health-care professionals in the labor-market area of the facility under subparagraph (B) determines (under regulations prescribed by the Secretary) that the size or composition of the labor-market area provides information that is not sufficient to permit the adjustments referred to in that subparagraph for the applicable covered positions, the director may conduct a survey of such rates of compensation in other comparable labor-market areas (as so determined). Any survey under this subparagraph shall be conducted in accordance with the provisions of subparagraph (B).

(D) In the event that the director of a Department health-care facility who conducts a survey of beginning rates of compensation for certified registered nurse anesthetists in the labor-market area of the facility under subparagraph (B), and, if appropriate, a survey of such rates of compensation for such nurse anesthetists in comparable labor-market areas under subparagraph (C), determines (under regulations prescribed by the Secretary) that neither of the survey methods described in such subparagraphs is sufficient to permit the adjustments referred to in subparagraph (B) for such nurse anesthetists employed by the facility, the director may use data on the beginning rates of compensation paid to certified registered nurse anesthetists who are employed on a salary basis by entities that provide anesthesia services through certified registered nurse anesthetists in the labor-market area. For the purposes of this subparagraph, certified registered nurse anesthetists who are so employed by such entities shall be deemed to be corresponding health-care professionals to the certified registered nurse anesthetists employed by the facility.

[(C)] *(E)* The Chief Medical Director shall prescribe regulations providing for the adjustment of the rates of basic pay for Regional

and Central Office employees in covered positions in order to assure that those rates are sufficient and competitive.

[(D)] *(F)* The director of a facility or Chief Medical Director may not adjust rates of basic pay under this subsection for any pay grade so that the minimum rate of basic pay for that grade is greater than the beginning rates of compensation for corresponding positions at non-Department health-care facilities.

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(6) In this subsection—

(A) The term "beginning rate of compensation", with respect to health-care personnel positions in non-Department health-care facilities corresponding to a grade of a covered position, means the sum of—

(i) the minimum rate of pay [established] *paid* for personnel in such positions who have education, training, and experience equivalent or similar to the education, training, and experience required for health-care personnel employed in the same category of Department covered positions; and

(ii) other employees benefits for those positions to the extent that those benefits are reasonably quantifiable.

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(g) * * *

(1) * * *

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(9) The justification required by section 7452(e)(2) of this title.

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§ 7452. Nurses and other health-care personnel: administration of pay

(a)(1) * * *

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(e)*(1)* An employee in a covered position employed under section 7401(1) of this title who (without a break in employment) transfers from one Department health-care facility to another may not be reduced in grade or step within grade (except pursuant to a disciplinary action otherwise authorized by law) if the duties of the position to which the employee transfers are similar to the duties of the position from which the employee transferred. The rate of basic pay of such employee shall be established at the new health-care facility in a manner consistent with the practices at that facility for an employee of that grade and step.

(2) The Secretary may establish for an employee referred to in paragraph (1) who transfers upon the request of the Secretary (but not pursuant to a disciplinary action otherwise authorized by law) to a new facility a rate of basic pay that is higher than the rate of basic pay otherwise paid by the new facility to an employee of that grade and step if the Secretary determines that such rate of pay is necessary to recruit the employee for employment in the new facility. Whenever the Secretary exercises the authority under the preceding sentence relating to the rate of basic pay of a transferred employee,

the Secretary shall, in the next annual report required under section 7451(g) of this title, provide justification for doing so.

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CHAPTER 76—HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

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SUBCHAPTER II—SCHOLARSHIP PROGRAM

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§ 7618. Expiration of program

The Secretary may not furnish scholarships to new participants in the Scholarship Program after [September 30, 1992.] *December 31, 1997.*

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY

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SUBCHAPTER II—PROCUREMENT AND SUPPLY

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§ 8125. Procurement of health-care items

(a) Except as provided in subsections (b) and (c) of this [section,] *section and section 8174(b) of this title,* the Secretary may not procure health-care items under local contracts.

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SUBCHAPTER III—STATE HOME FACILITIES FOR FURNISHING DOMICILIARY, NURSING HOME, AND HOSPITAL CARE

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§ 8133. Authorization of appropriations

(a) There are hereby authorized to be appropriated such sums as are necessary to carry out this [subchapter through September 30, 1992.] *subchapter.* Sums appropriated pursuant to this section shall be used for making grants to States which have submitted, and have had approved by the Secretary, applications for carrying out the purposes and meeting the requirements of this subchapter.

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§ 8135. Applications with respect to projects; payments

(a) * * *

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(b)(1) * * *

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(6)(A) The Secretary may conditionally approve a project under this section, conditionally award a grant for the project, and obligate funds for the grant if the Secretary determines that the application for the grant is sufficiently complete to warrant awarding the grant and that, based on assurances provide by the State submitting the application, the State will complete the application and meet all the requirements referred to in paragraph (1)(A) of this subsection by the date, not later than [90] *180* days after the date of the conditional approval, specified by the Secretary.

(B) If a State does not complete the application and meet all the requirements referred to in such paragraph by the date specified by the Secretary under subparagraph (A) of this paragraph, the Secretary shall rescind the conditional approval and award under such subparagraph and deobligate the funds previously obligated in connection with the application. *In the event the Secretary rescinds conditional approval of a project under this subparagraph, the Secretary may not further obligate funds for the project during the fiscal year in which the Secretary rescinds such approval.*

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§ 8136. Recapture provisions

If, within [20 years after completion] *the 20-year period beginning on the date of the approval by the Secretary of the final architectural and engineering inspection* of any project with respect to which a grant has been made under this subchapter (except that the Secretary, pursuant to regulations which the Secretary shall prescribe, may at the time of such grant provide for a shorter period than 20, but not less than seven years, based on the magnitude of the project and the grant amount involved, in the case of the acquisition, expansion, remodeling, or alteration of existing facilities), [such facilities] *the facilities covered by the project* cease to be operated by a State, a State home, or an agency or instrumentality of a State principally for furnishing domiciliary, nursing home, or hospital care to veterans, the United States shall be entitled to recover from the State which was the recipient of the grant under this subchapter, or from the then owner of such facilities, 65 percent of the then value of such project (but in no event an

amount greater than the amount of assistance provided under this subchapter), as determined by agreement of the parties or by action brought in the district court of the United States for the district in which such facilities are situated.

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SUBCHAPTER VI—PROCUREMENT OF DRUGS AND BIOLOGICALS

§ 8171. Definitions

For the purposes of this subchapter—

(1) The term "additional price discount amount," in the case of the price of a drug or biological whose price is established under an agreement under this subchapter, means—

(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months, the amount of the difference, if any, between—

(i) the Federal average price differential (as determined under paragraph (6)(A)); and

(ii) the amount equal to—

(I) the Federal average manufacturer price of the drug or biological for the 3-month period ending on the date that is 12 months before the last day of the last month before the effective date of the agreement for which price index data and price data for the drug or biological are available, multiplied by

(II) the percentage increase in the price index during that 12-month period; or

(B) in the case of a drug or biological for which such data does not permit the calculation of that price for as many months, the amount of the difference, if any, between—

(i) the Federal average price differential (as determined under paragraph (6)(B)); and

(ii) an amount equal to—

(I) the Federal average manufacturer price of the drug or biological for the 3-month period beginning on the first day of the month next following the month in which marketing of the drug or biological begins, multiplied by

(II) the percentage increase in the price index during the period beginning on such day and ending on the last day of the last month before the effective date of the agreement for which price index data are available.

(2) The term "covered drug or biological" means—

(A) any drug marketed under a new drug application approved by the Secretary of Health and Human Services under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(B) any biological marketed under a product licensing application approved by the Administrator of the Food and Drug Administration pursuant to section 351 of the Public Health Service Act (42 U.S.C. 262).

(3) The term "depot" means a centralized commodity management system operated by the Department through which drugs and biologicals procured for the use of entities of the Department are—

(A) received, stored, and delivered through—

(i) a warehouse system under the jurisdiction and operation of the Department; or

(ii) a commercial entity operating under contract with the Department; or

(B) delivered directly from the manufacturer to the entity using the drugs or biologicals.

(4) The term "depot price" means the price of a drug or biological under an agreement between the Secretary and the manufacturer of the drug or biological to determine the price of the drug or biological for purchase through depots.

(5) The term "Federal average manufacturer price", with respect to a covered drug or biological and a specified period of time, means the weighted average price of a single form and dose unit of the drug or biological that is paid to the manufacturer of the drug or biological, taking into account any cash discounts or similar price reductions, during that period by wholesalers (other than a price paid by the Federal Government).

(6) The term "Federal average price differential", with respect to a covered drug or biological whose price is established under an agreement under this subchapter, means—

(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months—

(i) the Federal average manufacturer price of the drug or biological during the 3-month period ending on the last day of the last month before the effective date of the agreement for which price data and price index data are available, minus

(ii) the Federal average manufacturer price of the drug or biological during the 3-month period ending on the date that is 1 year before the ending of such 3-month period; or

(B) in the case of a drug or biological for which such data does not permit the calculation of that price for as many months—

(i) the Federal average manufacturer price of the drug or biological during the 3-month period ending on the last day of the last month before effective date of the agreement for which price data are available, minus

(ii) the Federal average manufacturer price of the drug or biological during the 3-month period beginning on the first day of the first month next following the

month in which marketing of the drug or biological begins.

(7) The term "manufacturer," with respect to a drug or biological, means—

(A) an entity that both manufactures and distributes the drug or biological; or

(B) if no such entity exists, an entity that distributes the drug or biological.

The term does not include a wholesale distributor of drugs or biologicals, a retail pharmacy licensed under State law, or a practitioner licensed under State law and authorized to dispense drugs or biologicals.

(8) The term "price index" means the Producer Price Index—Finished Goods published monthly by the Bureau of Labor Statistics.

(9) The term "weighted average price," with respect to a covered drug or biological and a specified period of time, means—

(A) the sum of the products of—

(i) the average price per unit of each package quantity of the drug or biological sold during the period, and

(ii) the number of units of the drug or biological sold at that average price; divided by

(B) the total number of units of the drug or biological sold during the period.

§ 8172. Prices of drugs and biologicals under Federal Supply Schedule contracts

(a)(1) In accordance with the provisions of this section, the secretary may enter into agreements with the manufacturers referred to in paragraph (2) under which agreements the Secretary and such manufacturers shall provide for the price under the supply schedule of drugs and biologicals that are marketed by such manufacturers.

(2) The Secretary may enter into agreements under this section with each manufacturer of a drug or biological that enters into a master agreement with the Administrator of the General Services Administration with respect to that drug or biological under section 1001 of the Federal Property and Administrative Services Act of 1949.

(b) Subject to subsection (g), the price under an agreement under this section of a covered drug or biological that was listed on the supply schedule on September 1, 1990, and is listed on the supply schedule on the date of the enactment of this Act, shall be as follows:

(1) During the 1-year period beginning on the effective date of the agreement, the price shall be an amount no greater than .76 multiplied by an amount equal to—

(A) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is positive—

(i) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary by the manufacturer), minus

(ii) the additional price discount amount (as determined under section 8171(1)(A) of this title); or

(B) in the case of a drug or biological whose Federal average price differential is not positive (as determined under section 8171(6)(A) of this title), the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based).

(2) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period increased by the same percentage as the increase in the price index during the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

(c) Subject to subsection (g), the price under an agreement under this section of a covered drug or biological that was listed on the supply schedule on September 1, 1990, but not listed on the supply schedule on the date of the enactment of this Act, shall be as follows:

(1) During the 1-year period beginning on the effective date of the agreement, the price shall be an amount no greater than .76 multiplied by an amount equal to—

(A) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is positive—

(i) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary by the manufacturer), minus

(ii) the additional price discount amount (as determined under section 8171(1)(A) of this title); or

(B) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based).

(2) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during such the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

(d) Subject to subsection (g), the price under an agreement under this section of a covered drug or biological that was not listed on the supply schedule on September 1, 1990, but was approved by the Administrator of the Food and Drug Administration on or before the date of the enactment of this Act, shall be as follows:

(1) During the 1-year period beginning on the effective date of the agreement—

(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for a least 15 months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

(i) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is positive—

(I) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary by the manufacturer), minus

(II) the additional price discount amount (as determined under section 8171(1)(A) of this title); or

(ii) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based); or

(B) in the case of a drug or biological for which such data does not permit the calculation of Federal average manufacturer price for as many months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

(i) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(B) of this title) is positive—

(I) the Federal average manufacturer price of the drug or biological for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before the effective date of the agreement for which price data are available (as so based), minus

(II) the additional price discount amount (as determined under section 8171(1)(B) of this title); or

(ii) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(B) of this title) is not positive, the Federal average manufacturer price of the drug or biological for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before the effective date of the agreement for which price data are available (as so based).

(2) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during such the most recent 12-month period

before the commencement of such succeeding 1-year period for which price index data are available.

(e) Subject to subsection (g), the price under an agreement under this section of a covered drug or biological that is approved by the Administrator of the Food and Drug Administration after the date of the enactment of this Act shall be as follows:

(1) During the 1-year period beginning on the effective date of the agreement—

(A) in the case of a drug or biological for which data that is available before the effective date of the agreement permits the calculation of Federal average manufacturer price for at least 15 months, the price shall be an amount no greater than .76 multiplied by an amount equal to—

(i) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is positive—

(I) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary by the manufacturer), minus

(II) the additional price discount amount (as determined under section 8171(1)(A) of this title); or

(ii) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is not positive, the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based); or

(B) in the case of a drug or biological for which such data does not permit the calculation of Federal average manufacturer price for as many months, the price shall be an amount no greater than .76 multiplied by an amount equal to the Federal average manufacturer price of the drug or biological (as so based) for the period beginning on the first day of the month next following the month in which marketing of the drug or biological begins and ending on the last day of the last month before such effective date for which such data are available.

(2) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during such the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

(f) Subject to subsection (g), the price under an agreement under this section of a covered drug or biological whose price under the supply schedule was determined under subsection (b), (c), (d), or (e), or under this subsection, pursuant to an agreement that is expiring, shall be as follows:

(1) During the 1-year period beginning on the effective date of the agreement, the price may not exceed the price of the drug or biological under the expiring agreement during the 1-year period beginning on the effective date of the expiring agreement increased by the same percentage as the increase in the price index during the period beginning on the effective date of the expiring agreement and ending on the last day of the last month before the effective date of the agreement under this subsection for which price index data are available.

(2) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period, increased by the same percentage as the increase in the price index during the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

(g)(1) In entering into an agreement under subsections (b) through (f) for the price under the supply schedule of a covered drug or biological, the Secretary may provide for a price of a drug or biological during the 1-year period beginning on the effective date of the agreement that is nominally in excess (as determined by the Secretary) of the price that would be determined for the drug or biological during that period under that subsection if the Secretary determines that such excess price is in the best interests of the Department.

(2) If the Secretary exercises the authority under this section to establish an excess price with respect to the price of a drug or biological during a 1-year period, the determination of the amount of the increase in the price of the drug or biological for the succeeding 1-year period, if any, shall be based on such excess price.

(h) The price under an agreement under this section of a drug or biological (other than a covered drug or biological) shall be jointly determined by the Secretary and the manufacturer of the drug or biological.

(i)(1) Except as provided in paragraph (2), the Secretary shall enter into agreements with manufacturers under this section not later than the later of—

(A) 6 months after the date of the enactment of this section; or

(B) 30 days after the Secretary's notifies the manufacturers of the Secretary's intention to enter into such agreements.

(2) In the case of a drug or biological that is first marketed after the date that is 5 months after the date of the enactment of this section, the Secretary shall enter into an agreement referred to in paragraph (1) not later than the later of—

(A) 3 months after the date such marketing begins; or

(B) 30 days after the Secretary notifies the manufacturer of the Secretary's intention to enter into such an agreement.

(j) The Secretary shall determine the term of any agreement entered into by the Secretary and a manufacturer under this section.

§ 8173. Report and audit of prices of drug and biologicals

(a)(1) The manufacturer of a covered drug or biological whose price is determined by an agreement under section 8172 or 8174 of this title shall report to the Secretary the Federal average manufac-

turers price of the drug or biological during each calendar quarter in which the agreement is in force. The manufacturer shall report such price not more than 30 days after the expiration of a covered quarter.

(2) The reports required under paragraph (1) shall be in addition to the reports required under subparagraphs (A)(i) and (B) of subsection (b)(1), subparagraphs (A)(i) and (B) of subsection (c)(1), clause (i)(I) and (ii) of subsection (d)(1)(A), clauses (i)(I) and (ii) of subsection (d)(1)(B), clauses (i)(I) and (ii) of subsection (e)(1)(A), and subsection (e)(1)(B) of section 8172 of this title, under clauses (i)(I) and (ii) of section 8174(c)(1)(A) of this title, and under subsections (d) and (e) of section 8174 of this title. The reports required under such subparagraphs shall be submitted upon the request of the Secretary.

(b)(1) The Secretary may impose a civil monetary penalty in an amount equal to $10,000 on any manufacturer that fails to report the information required under paragraph (1) of subsection (a) on a timely basis. Such amount shall be paid to the Treasury. The amount of the penalty shall be increased by $10,000 for each day in which such information has not been reported, and such amount shall be paid to the Treasury. If such information with respect to a drug or biological is not reported within 90 days of the deadline imposed, the Secretary may prohibit the purchase of the drug or biological through the supply schedule or Department depots after the end of such 90-day period and until the date such information is reported but in no case shall such prohibition be for a period of less than 30 days.

(2) Any manufacturer that knowingly reports false information to the Secretary under paragraph (1) of subsection (a) or the provisions of law referred to in paragraph (2) of that subsection is subject to a civil monetary penalty in an amount not to exceed $100,000 for each item of false information reported. Such amount shall be paid to the Treasury.

(3) The civil money penalties described in paragraphs (1) and (2) are in addition to other penalties as may be prescribed by law.

(c) In order to determine the accuracy of any price of a drug or biological that is reported to the Secretary under the provisions of law referred to in subsection (b)(2), the Secretary may audit—

(1) the relevant records of any manufacturer of a covered drug or biological that is the subject of an agreement under subsections (b) through (f) of section 8172 or under subsections (c) through (f) of section 8174 of this title; and

(2) the relevant records of any wholesaler that distributes such a drug or biological.

(d) All information contained in a report submitted to the Secretary under this section by a manufacturer shall remain confidential.

§ 8174. Procurement of drugs and biologicals through Department depots

(a) The Secretary shall enter into agreements with manufacturers referred to in section 8172(a)(2) of this title under which agreements the Secretary and such manufacturers shall determine the prices of drugs and biologicals manufactured by such manufacturers and available for purchase through depots of the Department.

(b) Notwithstanding section 8125(a) of this title, the Secretary may procure for any Department health-care facilities any drug or biological that is subject to an agreement under this section.

(c)(1) Subject to paragraph (2), the price under an agreement under subsection (a) of a covered drug or biological that was the subject of a contract for procurement by the Department through a depot on September 1, 1990, shall be as follows:

(A) During the 1-year period beginning on the effective date of the agreement, the price shall be an amount no greater than .76 multiplied by an amount equal to—

(i) in the case of a drug or biological whose Federal average price differential (as determined under section 8171(6)(A) of this title) is positive—

(I) the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (based on reports of such price to the Secretary by the manufacturer), minus

(II) the additional price discount amount (as determined under section 8171(1)(A) of this title); or

(ii) in the case of a drug or biological whose Federal average price differential is not positive (as determined under section 8171(6)(A) of this title), the Federal average manufacturer price of the drug or biological for the most recent 12-month period before such effective date for which data used to calculate such price are available (as so based).

(B) During a succeeding 1-year period (including a 1-year period that succeeds a succeeding 1-year period), the price may not exceed the price of the drug or biological during the preceding 1-year period increased by the same percentage as the increase in the price index during the most recent 12-month period before the commencement of such succeeding 1-year period for which price index data are available.

(2)(A) In entering into an agreement under paragraph (1) for the price of a drug or biological, the Secretary may provide for a price of a drug or biological during the 1-year period beginning on the effective date of the agreement that is nominally in excess (as determined by the Secretary) of the price that would be determined for the drug or biological during that period under that paragraph if the Secretary determines that such excess price is in the best interests of the Department.

(B) If the Secretary exercises the authority under this section to establish an excess price with respect to the price of a drug or biological during a 1-year period, the determination of the amount of the increase in the price of the drug or biological for the succeeding 1-year period, if any, shall be based on such excess price.

(d) The price under an agreement under subsection (a) of a covered drug or biological that was not the subject of a contract referred to in subsection (c) on September 1, 1990, but was approved by the Administrator of Food and Drug Administration on or before the date of the enactment of this Act, shall be determined in the manner set forth for the determination of the price of a drug or biological under section 8172(d) of this title.

(e) The price under an agreement under subsection (a) of a covered drug or biological that is approved by such Administrator after such date, shall be determined in the manner set forth for the determination of the price of a drug or biological under section 8172(e) of this title.

(f) The price under an agreement under subsection (a) of a covered drug or biological whose price was determined under subsections (c), (d), (e), or under this subsection, pursuant to an agreement that is expiring, shall be determined in the manner set forth for the determination of the price of a drug of biological under section 8172(f) of this title.

(g) The price under an agreement under subsection (a) of a drug or biological (other than a covered drug or biological) shall be jointly determined by the Secretary and the manufacturer of the drug or biological.

(h)(1) Except as provided in paragraph (2), the Secretary shall enter into agreements with manufacturers under this section not later than the later of—

(A) 6 months after the date of the enactment of this section; or

(B) 30 days after the Secretary notifies the manufacturers of the Secretary's intention to enter into such agreements.

(2) In the case of a drug or biological that is first marketed after the date that is 5 months after the date of the enactment of this section, the Secretary shall enter into an agreement referred to in paragraph (1) not later than the later of—

(A) 3 months after the date such marketing begins; or

(B) 30 days after the Secretary notifies the manufacturer of the Secretary's intention to enter into such an agreement.

(i) The Secretary shall determine the term of any agreement entered into by the Secretary and a manufacturer under this section.

§ 8175. Prices of drugs and biologicals purchased by State homes

In the event that a State home procures a drug or biological listed on the supply schedule, the price of the drug or biological shall be not more than the price of the drug or biological on the supply schedule on the date of the procurement.

§ 8176. Unified pharmaceutical award contracts

(a) The Secretary may, on behalf of the entities referred to in subsection (b), negotiate and enter into one or more unified pharmaceutical award contracts (hereafter in this section referred to as a "UPAC") with manufacturers relating to the procurement by such entities under such contracts of drugs or biologicals that are manufactured by such manufacturers.

(b)(1) Subject to paragraph (2), an entity on whose behalf the Secretary may enter into a UPAC under this section in any of the following entities that procures a drug or biological in connection with the furnishing of health care services:

(A) A department or agency of the Federal Government, including the Department of Veterans Affairs.

(B) A department, agency, other division or unit of a State (including a State home), county, or municipality.

(C) A Public Health Service clinic of the type described in section 2145(a) of the Public Health Service Act which the Secretary of Health and Human Services has certified is eligible to receive a discount under such section 2145.

(2) The Secretary may not negotiate or enter into a UPAC on behalf of an entity unless the entity enters into an agreement with the Secretary—

(A) to participate in a UPAC on a basis to be determined by the Secretary;

(B) to purchase under the UPAC a quantity (as determined by the Secretary) of the drug or biological that is the subject of the UPAC;

(C) to provide to the Secretary adequate evidence (as determined by the Secretary) of the entity's fiscal capability of making the purchase referred to in subparagraph (B);

(D) to ensure that the drug or biological purchased through the UPAC is not resold; and

(E) to pay into the revolving supply fund referred to in section 8121 of this title an amount that the Secretary determines is sufficient to cover any administrative costs of the Secretary in negotiating, entering into, or administering the UPAC.

(c)(1) A entity on whose behalf the Secretary enters into a UPAC under this section with respect to a drug or biological may not—

(A) resell or otherwise transfer the drug or biological to a person other than a patient of the entity;

(B) purchase the drug or biological on behalf of any person or entity other than the entity on whose behalf the Secretary enters into the UPAC; or

(C) dispense or administer, directly or through a contract, the drug or biological to an individual who is not receiving the drug or biological as a patient of the entity.

(2)(A) An entity found to have sold, dispensed, or administered a drug or biological in violation of this subsection shall be subject to a civil penalty in the amount of $25,000 for each such violation. Such amount shall be paid to the Treasury.

(B) The civil money penalty referred to in subparagraph (A) is in addition to any other such penalties as may be prescribed by law.

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FEDERAL PROPERTY AND ADMINISTRATIVE SERVICES ACT OF 1949

(Public Law 81-152, June 30, 1949)

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TITLE X—PHARMACEUTICAL PRICING AGREEMENTS

SEC. 1001. MASTER AGREEMENTS.

(a) IN GENERAL.—(1)(A) A manufacturer of a drug or biological may not—

(i) sell drugs or biologicals to any Federal agency described under subsection (b),

(ii) be deemed to have an agreement under section 1927 of the Social Security Act (42 U.S.C. 1396r-8), or

(iii) receive payment for the purchase of a drug or biological directly or indirectly from any entity that receives funds under the Public Health Service Act (42 U.S.C. 201 et seq.),

unless such manufacturer enters into an agreement with the Administrator as described in subparagraph (B)(i) within 5 months of the date of the enactment of this title or, in the case of a drug or biological first marketed by such manufacturer after such date, such manufacturer complies with the requirements of paragraph (2).

(B)(i) An agreement is described in this subparagraph if such agreement requires a manufacturer referred to in subparagraph (A) to enter into one or more pharmaceutical pricing agreements with Federal agencies desiring such agreements with respect to any drug or biological marketed by such manufacturer within 6 months of the date of the enactment of this title, or, if such a pricing agreement is not desired by a Federal agency within such period, within 30 days after such Federal agency requests such a pricing agreement.

(ii) The Administrator shall prescribe procedures under which a Federal agency shall notify a drug or biological manufacturer that the Federal agency desires to enter into a pharmaceutical pricing agreement under clause (i).

(2) Any manufacturer of a drug or biological first marketed after the date of the enactment of this title shall—

(A) within 2 months after the date such marketing begins—

(i) if the manufacturer has an agreement with the Administrator under paragraph (1)(A), enter into an amendment of such agreement with respect to such drug or biological, or

(ii) if the manufacturer does not have an agreement with the Administrator under paragraph (1)(A), enter into such an agreement with respect to such drug or biological; and

(B) enter into pharmaceutical pricing agreement with respect to such drug or biological—

(i) within 3 months after the date such marketing begins; or

(ii) if such a pricing agreement is not desired by a Federal agency within such 3-month period, within 30 days after such Federal agency requests such a pricing agreement.

(b) FEDERAL AGENCIES.—Federal agencies described in this subsection are as follows:

(1) The Department of Veterans Affairs with respect to sales to the Department of Veterans Affairs and State homes receiving funds under section 1741 of title 38, United States Code.

(2) The Department of Defense.

(3) The Department of Health and Human Services with respect to sales to the Public health Service and certain clinics described in section 2145(a) of the Public Health Service Act.

(c) PHARMACEUTICAL PRICING AGREEMENTS.—For purposes of subsection (a), the term "pharmaceutical pricing agreement" means an agreement or amendments to an agreement in force on the date of the enactment of this title with any Federal agency described in subsection (b) or with the Department of Health and Human Services under title XIX of the Social Security Act regarding pharmaceutical pricing and subject to the following relevant provisions:

(1) Subchapter VI of chapter 81 of title 38, United States Code.

(2) Section 1107 of title 10, United States Code.

(3) Section 1927 of the Social Security Act (42 U.S.C. 1396r-8).

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